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## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6885

## CERTIFICATE OF DEATH

Reg. Dist. No. 06871

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>one month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>ALDER</b> Last <b>ALDER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1875</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR: Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Treasury Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mr. William H. Alder</b>		14. MOTHER'S MAIDEN NAME <b>Amelia C. Washington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Frances J. Crown</b>		Address <b>14428 Colesville Rd. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>Hypertension Atherosclerotic Cerebral Vascular Disease</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1, 1961</b> , to <b>June 12, 1961</b> , that I last saw the deceased alive on <b>June 12, 1961</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P.P. Andrews</b>		ADDRESS (Street, city or town, state) <b>4201 Fessenden St. N.W. Washington 16 D.C.</b>	
PHYSICIAN'S NAME (Type) <b>P.P. ANDREWS</b>		DATE SIGNED <b>6-12-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/14/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lovettsville, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>		ADDRESS <b>8434 Georgia Avenue Silver Spring, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

CERTIFICATE OF DEATH

1918

M

<p>NAME OF DECEASED</p> <p>AGE</p> <p>SEX</p> <p>RACE</p> <p>DATE OF BIRTH</p> <p>DATE OF DEATH</p> <p>PLACE OF BIRTH</p> <p>PLACE OF DEATH</p> <p>CAUSE OF DEATH</p> <p>DIAGNOSIS</p> <p>PREVIOUS ILLNESS</p> <p>PREVIOUS SURGERY</p> <p>PREVIOUS TRAUMA</p> <p>PREVIOUS DRUGS</p> <p>PREVIOUS ALCOHOL</p> <p>PREVIOUS TOBACCO</p> <p>PREVIOUS OTHER</p> <p>PREVIOUS OCCUPATION</p> <p>PREVIOUS HOBBIES</p> <p>PREVIOUS RELIGION</p> <p>PREVIOUS EDUCATION</p> <p>PREVIOUS MARRIAGE</p> <p>PREVIOUS CHILDREN</p> <p>PREVIOUS PARENTS</p> <p>PREVIOUS SIBLINGS</p> <p>PREVIOUS OTHER</p>		<p>DATE OF DEATH</p> <p>PLACE OF DEATH</p> <p>CAUSE OF DEATH</p> <p>DIAGNOSIS</p> <p>PREVIOUS ILLNESS</p> <p>PREVIOUS SURGERY</p> <p>PREVIOUS TRAUMA</p> <p>PREVIOUS DRUGS</p> <p>PREVIOUS ALCOHOL</p> <p>PREVIOUS TOBACCO</p> <p>PREVIOUS OTHER</p> <p>PREVIOUS OCCUPATION</p> <p>PREVIOUS HOBBIES</p> <p>PREVIOUS RELIGION</p> <p>PREVIOUS EDUCATION</p> <p>PREVIOUS MARRIAGE</p> <p>PREVIOUS CHILDREN</p> <p>PREVIOUS PARENTS</p> <p>PREVIOUS SIBLINGS</p> <p>PREVIOUS OTHER</p>
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6886

06872

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>114 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>6008 Avon Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mark</b>		<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>13</b> Year <b>19 61</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>3-18-91</b>		<b>9. AGE</b> (In years last birthday) <b>70</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Kentucky</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>																	
<b>13. FATHER'S NAME</b> <b>William R. ALLEN</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Clara KEYES</b>																	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>579-38-7559A</b> (S) <b>Wm. O. Allen, same as #2 above</b>																	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Bronchogenic carcinoma</b> <b>162.1</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>DUE TO</b> <b>(b)</b> <b>(c)</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																					
<b>20c. TIME OF INJURY</b> Hour <b>19</b> Month, Day, Year <b>19 61</b> a.m. p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)													
<b>21. I certify that</b> <b>he</b> (this hospital) <b>attended the deceased from</b> <b>Feb. 19 1961</b> <b>to</b> <b>June 13 1961</b> , <b>that</b> <b>he</b> (we) <b>last saw the deceased alive on</b> <b>June 13 1961</b> , <b>and that death occurred at</b> <b>11:20PM</b> , <b>from the causes and on the date stated above.</b>																					
<b>22a. SIGNATURE</b> <b>22b. DATE SIGNED</b> <b>6-14-61</b>																					
<b>22c. PHYSICIAN'S NAME</b> (Type or print) <b>Paul G. LINAWEAVER, JR., M.D., MC, USN</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>6-16-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ft. Lincoln Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Washington, D. C.</b>													
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>R. A. Pumphrey</b>				<b>ADDRESS</b> <b>Ft. Lincoln Cemetery</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUN 16 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hanks</b>													

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Department of Health and Human Services

Office of the Assistant Secretary for Health

Office of the Assistant Secretary for Health

Office of the Assistant Secretary for Health

Office of the Assistant Secretary for Health

Office of the Assistant Secretary for Health

Office of the Assistant Secretary for Health

Office of the Assistant Secretary for Health

Office of the Assistant Secretary for Health

Feb. 10, 1961

Dr. C. W. Smith, M.D., F.R.C.P., F.R.C.S., F.R.C. (S), F.R.C. (G), F.R.C. (A), F.R.C. (C), F.R.C. (E), F.R.C. (I), F.R.C. (M), F.R.C. (N), F.R.C. (O), F.R.C. (P), F.R.C. (Q), F.R.C. (R), F.R.C. (S), F.R.C. (T), F.R.C. (U), F.R.C. (V), F.R.C. (W), F.R.C. (X), F.R.C. (Y), F.R.C. (Z)

Dr. C. W. Smith, M.D., F.R.C.P., F.R.C.S., F.R.C. (S), F.R.C. (G), F.R.C. (A), F.R.C. (C), F.R.C. (E), F.R.C. (I), F.R.C. (M), F.R.C. (N), F.R.C. (O), F.R.C. (P), F.R.C. (Q), F.R.C. (R), F.R.C. (S), F.R.C. (T), F.R.C. (U), F.R.C. (V), F.R.C. (W), F.R.C. (X), F.R.C. (Y), F.R.C. (Z)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06873

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

6903 Oakridge Ave.

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

54 Chevy Chase

d. STREET ADDRESS

16903 Oakridge Ave. =

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

First

DEAN

Middle

JOHNSON

Last

ALMY

### 4. DATE OF DEATH

Month

June

Day

23,

Year

1961

### 5. SEX

Male

### 6. COLOR OR RACE

White

### 7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

### 8. DATE OF BIRTH

Jan. 27, 1898

### 9. AGE (In years last birthday)

63 yrs.

### 10. IF UNDER 1 YEAR

Months 4 Days 26

### 11. IF UNDER 24 HRS.

Hours Min.

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life)

Chief of Exchange Regulations SEC

### 10b. KIND OF BUSINESS OR INDUSTRY

U. S. Gov't

### 11. BIRTHPLACE (County & State, or foreign country)

Portsmouth, N. H.

### 12. CITIZEN OF WHAT COUNTRY?

U. S. A.

### 13. FATHER'S NAME

Charles E. Almy

### 14. MOTHER'S MAIDEN NAME

Isabella Yates Helen Johnson

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

Yes

### 16. SOCIAL SECURITY NO.

Unknown

### 17. INFORMANT

Address

David O. Almy-son-same 2d

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

#### PART I. DEATH WAS CAUSED BY:

#### IMMEDIATE CAUSE (a)

Squamous cell carcinoma of esophagus grade III 6 mos

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

#### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

### 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

### 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

### 20c. TIME OF INJURY

Hour e.m.

Month, Day, Year

p.m.

19

### 20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

### (County)

### (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 10, 1961 to June 22, 1961, that (I) (we) last saw the deceased alive on June 22, 1961, and that death occurred at 7 A.M. from the causes and on the date stated above.

### 22a. SIGNATURE

Arnold Mc Nitt

M.D.

### ATTENDING PHYS.

☒

### MED. DIRECTOR

☐

### STAFF PHYS.

☐

6-23-61

### 22b. DATE SIGNED

### 22c. PHYSICIAN'S NAME (Type)

ARNOLD McNITT

### 22d. ADDRESS

1835 I Street, N. W., Washington, D.C.

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

### 23b. DATE THEREOF

6/27/61

### 23c. NAME OF CEMETERY OR CREMATORY

Arlington National Cem. Arlington, Virginia

### 23d. LOCATION (City, town or county)

### (State)

### 24 FUNERAL DIRECTOR'S SIGNATURE

ROBERT A. PUMPHREY

### ADDRESS

Bethesda, Md.

### 25a. REC'D BY REGISTRAR

JUN 27 '61

### 25b. REGISTRAR'S SIGNATURE

Arthur L. Hays

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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29 January 1944

General The Will

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Washington National ...  
Hendricks, ...

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6888

06874

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
c. LENGTH OF STAY IN 1b <b>4 1/2 days</b>				d. STREET ADDRESS <b>900 Lincoln St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frederick A. Bacher</b>				4. DATE OF DEATH <b>June 12 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/20/81</b>	
9. AGE (In years, last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Insurance Salesman</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Philip Bacher</b>				14. MOTHER'S MAIDEN NAME <b>Jenny Hickok</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>333-14-9120</b>		17. INFORMANT <b>Hilda Bacher(wifw)</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Congestive Heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>10 1/2 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 11, 1961</b> to <b>June 12, 1961</b> ; that (I) (we) last saw the deceased alive on <b>June 11, 1961</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>G. Bowditch Hunter, Jr.</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>June 12, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>6/14/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Creamtory</b>		23d. LOCATION (City, town or county) (State) <b>Prince George's Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				25a. REC'D BY REGISTRAR <b>JUN 19 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



(M)

(I)

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C. B. Smith & Co., Inc.

James H. Smith  
C. B. Smith & Co., Inc.  
June 15, 1954

Copyright (C) 1954  
C. B. Smith & Co., Inc.  
June 15, 1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6889

Item 14 from Group 6/27/61 iwk

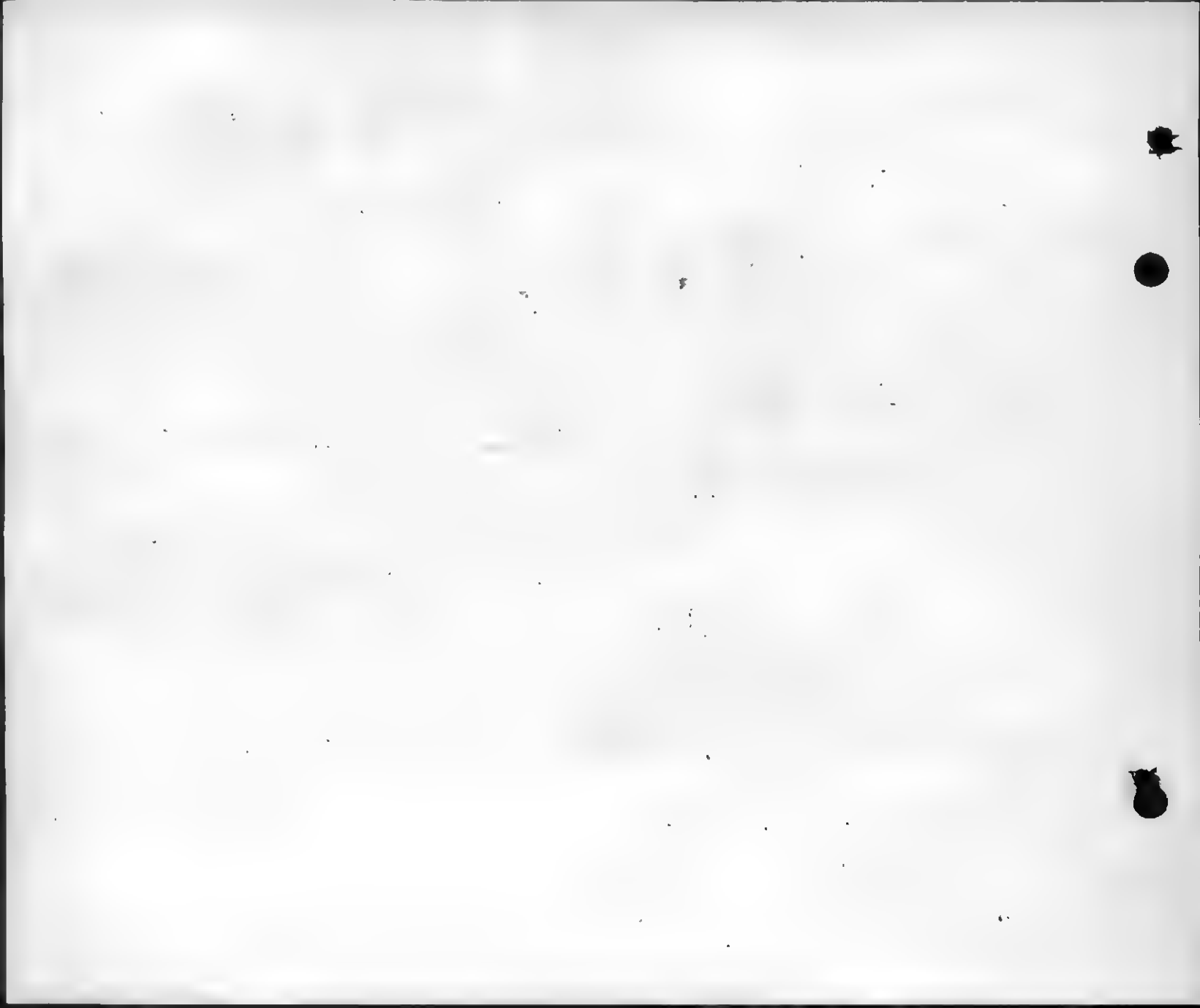
CERTIFICATE OF DEATH

Reg. Dist. No. 06875

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring 46</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10404 Ga. Ave.</b>				d. STREET ADDRESS <b>10404 Ga. Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>BAKER</b> Last <b>BAKER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 14, 1883</b>	
9. AGE (In years last birthday) <b>78</b> yrs		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Elliot Baker</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Rebecca Baker-10404 Ga. Ave. S.S. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X Myocardial Infarction</b>				<b>4 days</b>			
DUE TO (b) <b>Partial Obstruction</b>				<b>2 weeks</b>			
DUE TO (c) <b>Carcinoma of Stomach &amp; Metastases</b>				<b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Buerger Disease</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o</b> m <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 10</b> , 19 <b>58</b> , to <b>June 21</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>June 20</b> , 19 <b>61</b> , and that death occurred at <b>9:45</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Francis X. Richardson</b> M.D.				ADDRESS (Street, city and town, state) <b>11412 Viers Mill Rd. Beltsville Md. 6/21/61</b>			
DATE SIGNED <b>6/21/61</b>							
PHYSICIAN'S NAME (Type) <b>Francis X. Richardson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/22/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elesavetgrad Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS</b> ADDRESS <b>3501-14th St NW</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 23 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Evans</b>	

I

MEDICAL CERTIFICATION



TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
6820									
06876									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b. <b>1</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b> d. STREET ADDRESS <b>12 Princeton St.</b>				
3. NAME OF DECEASED (Type or print) <b>MARY JANE BAKER</b>					4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>19 61</b>				
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>Nov. 21, 1918</b> 9. AGE (In years; last birthday) <b>42</b> yrs. 10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>24</b> 11. IF UNDER 24 HRS.: Hours <b>6</b> M. n. <b>24</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Teaching</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>Oscar H. Stitt</b>					14. MOTHER'S MAIDEN NAME <b>Sarah Drury</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>Unknown</b> 17. INFORMANT <b>Husband</b> Address <b>Same as Item #2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (b) <b>Chronic Glomerulo Nephritis</b> (a), stating the underlying cause last, (c) <b>15 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>June 9, 1961</b> to <b>June 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 15, 1961</b> , and that death occurred at <b>11:55 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>DeWitt E. DeLauter</b> M.D. 22b. DATE SIGNED <b>6-15-61</b>					22c. PHYSICIAN'S NAME (Type) <b>DeWitt E. DeLauter</b> 22d. ADDRESS <b>3848 Porter St., N.W., Washington, D. C.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>6/19/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b> 23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>					25a. REC'D BY REGISTRAR <b>JUN 19 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>									





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06877

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ulnes  
c. LENGTH OF STAY IN 1b DOA  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Monty Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE md b. COUNTY Carroll  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine  
d. STREET ADDRESS Ashley Traylor Court

3. NAME OF DECEASED (Type or print) Tonia  
4. DATE OF DEATH June 22 1961  
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 5-31-61 9. AGE in years IF UNDER 1 YEAR: 21 IF UNDER 24 HRS. (last birthday) Months Days Hours Min. 21

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) md 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Donald Baker 14. MOTHER'S MAIDEN NAME Virginia Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None 16. SOCIAL SECURITY NO. None 17. INFORMANT Virginia Baker (mother) Address Item 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Asphyxia  
475X DUE TO  
Conditions, if any, which gave rise to immediate cause (b) severe Respiratory Infection  
(a), stating the underlying cause last. DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐ 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschert M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) FRANK J. Broschert ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 6-23-61  
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6-24-61 22c. NAME OF CEMETERY OR CREMATORY Lakewood Memorial Park 22d. LOCATION (City, town, or country) (State) Hykunda, Carroll Co., Md.

23. FUNERAL DIRECTOR Arthur H. Haight ADDRESS Hykunda, Md. 24a. REC'D BY REGISTRAR JUN 26 '61 24b. REGISTRAR'S SIGNATURE Arthur H. Haight



TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 4 hours after death. It may be retained in the hospital or at the funeral home for 48 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

6892

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

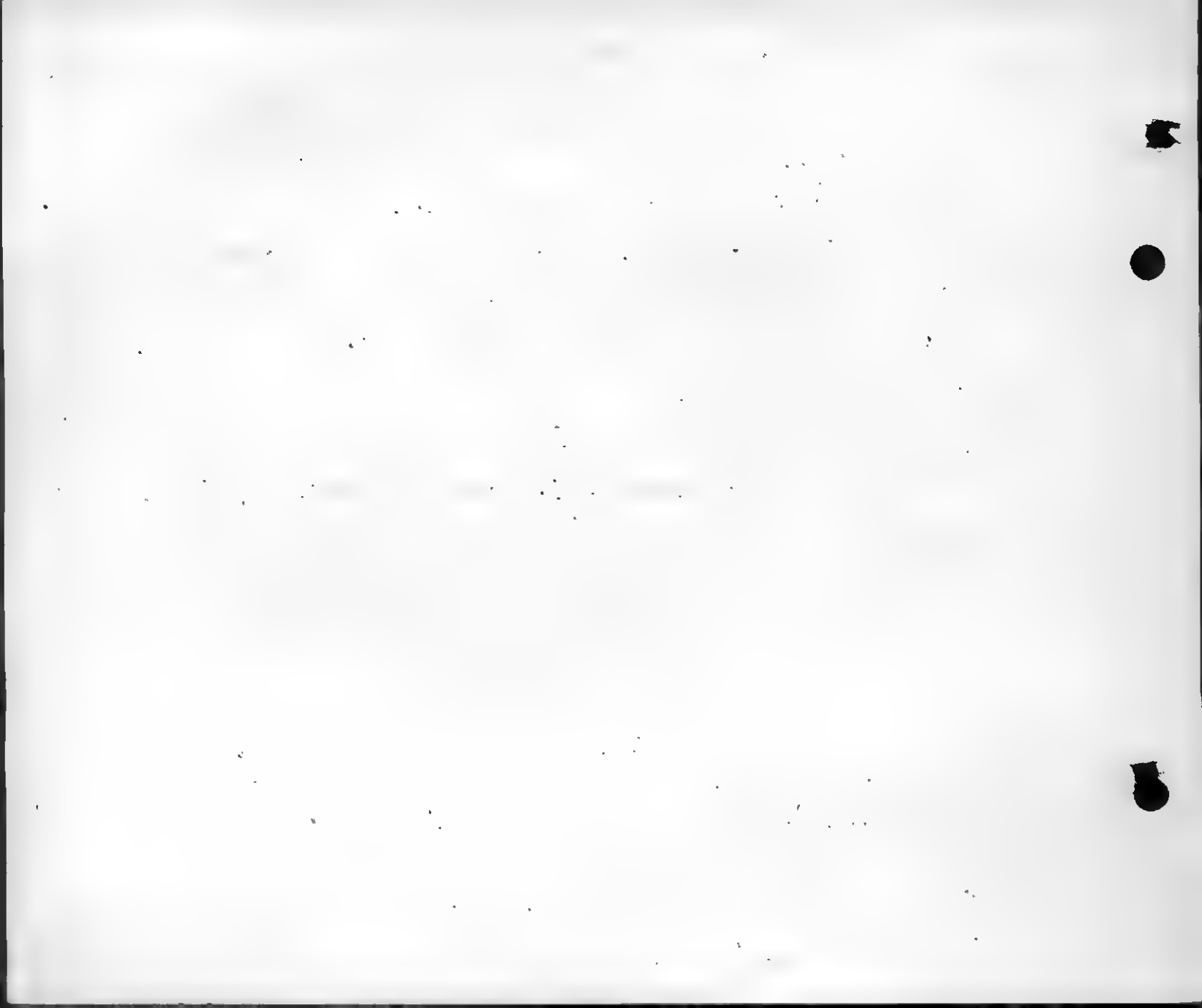
CERTIFICATE OF DEATH

Reg. Dist. No. 06878

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DC- 47X-3</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARYLANDER REST HOME</u>				d. STREET ADDRESS <u>2306 TUNLAW RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET T. BAPTISTA</u>				4. DATE OF DEATH Month Day Year <u>June 11 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 3 1875</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN F. McALWEE</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT <u>NEPHEW</u> <u>BENJAMIN V. McALWEE</u>		Address <u>4201 BROOKSIDE McLEAN VA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, left breast with generalized metastases</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1961</u> to <u>6/11, 1961</u> that I last saw the deceased alive on <u>6/9, 1961</u> , and that death occurred at <u>850P M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kerr</u> M.D.				ADDRESS (Street, city or town, state) <u>Washington, DC</u>		DATE SIGNED <u>6/11/61</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-14-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeVal FUNERAL HOME</u>				ADDRESS <u>2224 WIS Ave WASH. D.C.</u>		24a. REC'D BY REGISTRAR <u>JUN 19 61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thrash</u>			

M

I



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6893

## CERTIFICATE OF DEATH

06879

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN IT <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>4819 Rugby Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Franklin</b> Last <b>Barnes</b>				4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 27, 1884</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR: Months <b>7</b> Days <b>7</b>		IF UNDER 24 HRS.: Hours <b>7</b> Min. <b>7</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Barnes</b>				14. MOTHER'S MAIDEN NAME <b>Rosa Queen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 1901</b>				16. SOCIAL SECURITY NO. <b>1901</b>		17. INFORMANT <b>Son - Myer H. Barnes Bethesda Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Branchiopneumonia</b> Conditions, if any, which gave rise to immediate cause (b) <b>Intracerebral hemorrhage</b> (a), stating the underlying cause last. DUE TO (c) <b>10 days</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 25th</b> , 1961, to <b>June 30</b> , 1961, that (I) (we) last saw the deceased alive on <b>June 29, 1961</b> , and that death occurred at <b>P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. T. Joyce</b> M.D.				22b. DATE SIGNED		22c. ADDRESS <b>8106 Maple Ridge Rd. Bethesda, Md.</b>	
22d. PHYSICIAN'S NAME (Type) <b>William T. Joyce, M.D.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/3/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shinnwood Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Washington DC</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Funeral Home Inc. 5103 Mm</b>				25a. REC'D BY REGISTRAR <b>BUL 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

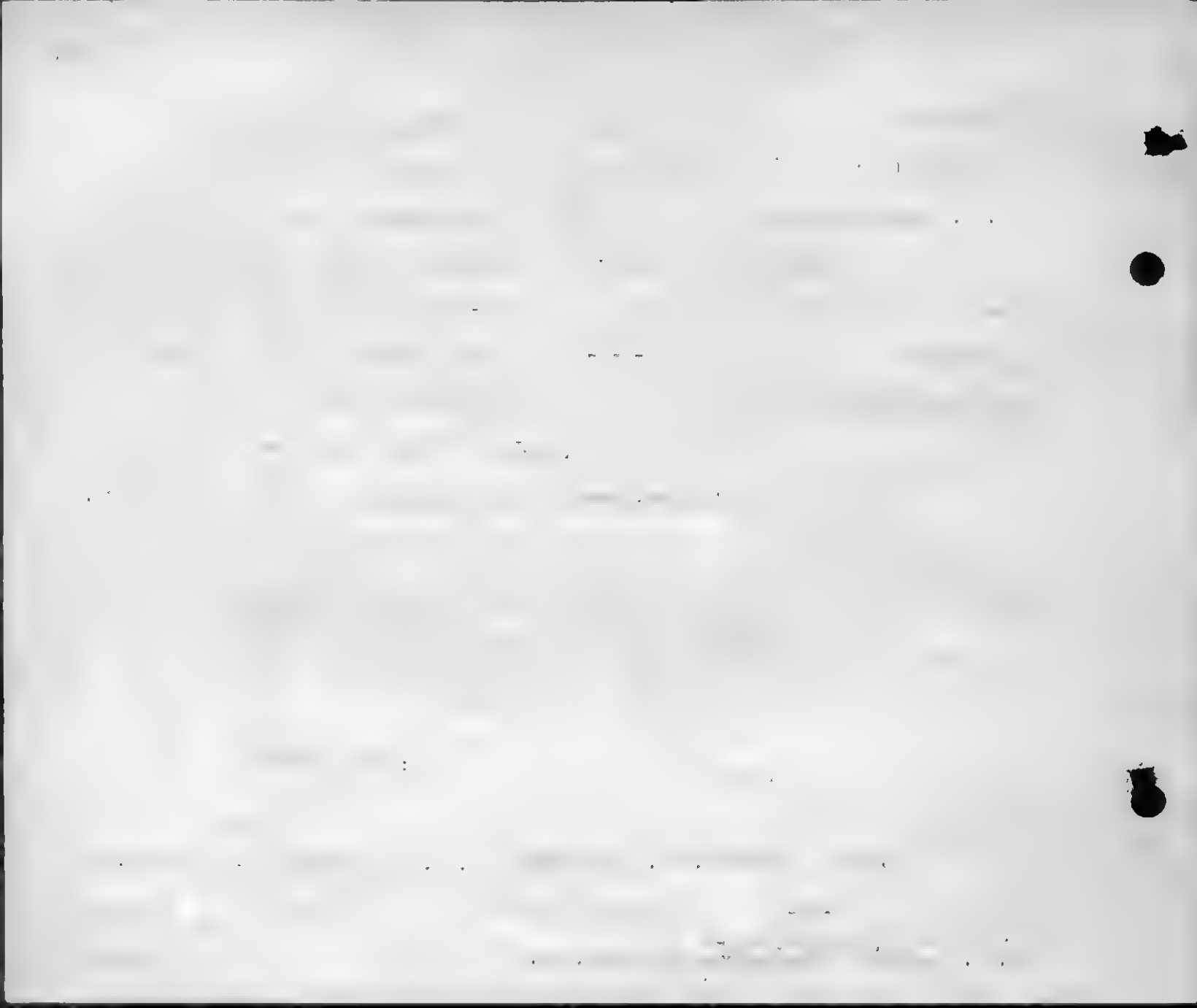
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6894

06880

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>5504 Damascus Street</b>	
3. NAME OF DECEASED (Type or print) <b>Betty Baker</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-24-17</b>	
9. AGE (In years last birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Norman Hempstead BAKER</b>		14. MOTHER'S MAIDEN NAME <b>Genevieve CAMPBELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>(H) James V. Bartlett, same as #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, breast, with metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>170X</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>19</b> (this hospital) attended the deceased from <b>May 24, 1961</b> to <b>June 14, 1961</b> that <b>19</b> (we) last saw the deceased alive on <b>June 14, 1961</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James J. Ryskamp, Jr., LT, MC, USN</b>		22b. DATE SIGNED <b>6-14-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James J. RYSKAMP, JR., LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-16-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 16 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



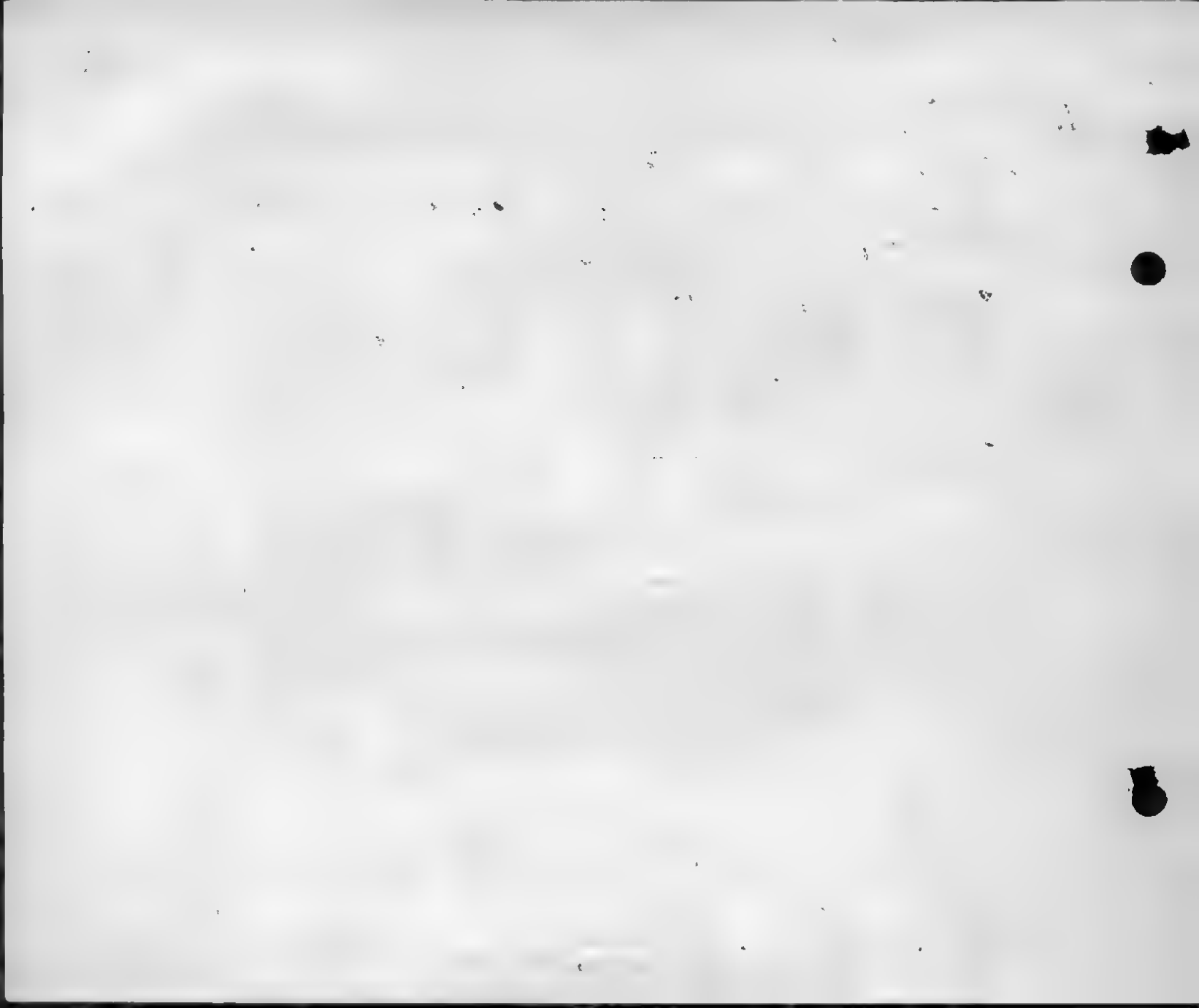
CERTIFICATE OF DEATH

06881

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u></u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>6 days</u>	
c. NAME OF DECEASED (Type or print) <u>Dessie Kimball Basinger</u>		d. STREET ADDRESS <u>6723 2nd St NW</u>	
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/> B. DATE OF BIRTH <u>6/17/93</u>	6. DATE OF DEATH <u>6</u> <u>6</u> <u>19</u> <u>61</u>
7. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	8. KIND OF BUSINESS OR INDUSTRY <u></u>	9. AGE (in years last birthday) <u>67</u> yrs.	10. IF UNDER 1 YEAR <u>11</u> Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min.
11. FATHER'S NAME <u>Daniel</u>	12. MOTHER'S MAIDEN NAME <u>Elesia Sowers</u>	13. CITIZEN OF WHAT COUNTRY? <u>America</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u>	15. SOCIAL SECURITY NO. <u>579-01-7597</u>	16. INFORMANT <u>Hosp record</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Coronary Infarct Acute</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Postero-Lateral Wall</u> <u>Coronary Infarct, old, multiple. Undetermined</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Coronary Arterio-sclerosis</u>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1961</u> to <u>June 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 6, 1961</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George L Ball</u> M.D.		22b. DATE SIGNED <u>June 6, 1961</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>George L Ball</u>		22d. ADDRESS <u>10620 Georgia Ave Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/9/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (city, town or county) (State) <u>Princes George's County, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 9 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6896

06882

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>N. J.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Irvington</u> d. STREET ADDRESS <u>98 Grace St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ethel</u> First <u>Anita</u> Middle <u>Beatty</u> Last		<b>4. DATE OF DEATH</b> Month <u>6</u> - Day <u>24</u> Year <u>1961</u>		<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>6-24-25</u>		<b>9. AGE (in years last birthday)</b> <u>35</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Graphic Arts</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pa.</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Wellington Jackson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Helen Jones</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>Washington Sanitarium &amp; Hospital Records</u> Address _____			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> (b) <u>11.7</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Concussion of Cranium</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____							
<b>20c. TIME OF INJURY</b> Hour _____ e.m. _____ p.m. _____ Month, Day, Year _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 4, 1961</u> , to <u>June 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 24, 1961</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Lytle Williams</u>		<b>22b. DATE SIGNED</b> _____		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Lytle Williams</u>			
<b>22d. ADDRESS</b> <u>8700 Lakesville Rd. Silver Spring, Md.</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u> <b>23b. DATE THEREOF</b> <u>6/26/1961</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hollywood Mem. Park</u> <b>23d. LOCATION (City, town or county)</b> <u>Union, N.J.</u> (State) _____					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph Sawler's Sons</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>JUN 27 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Chaud</u>			

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

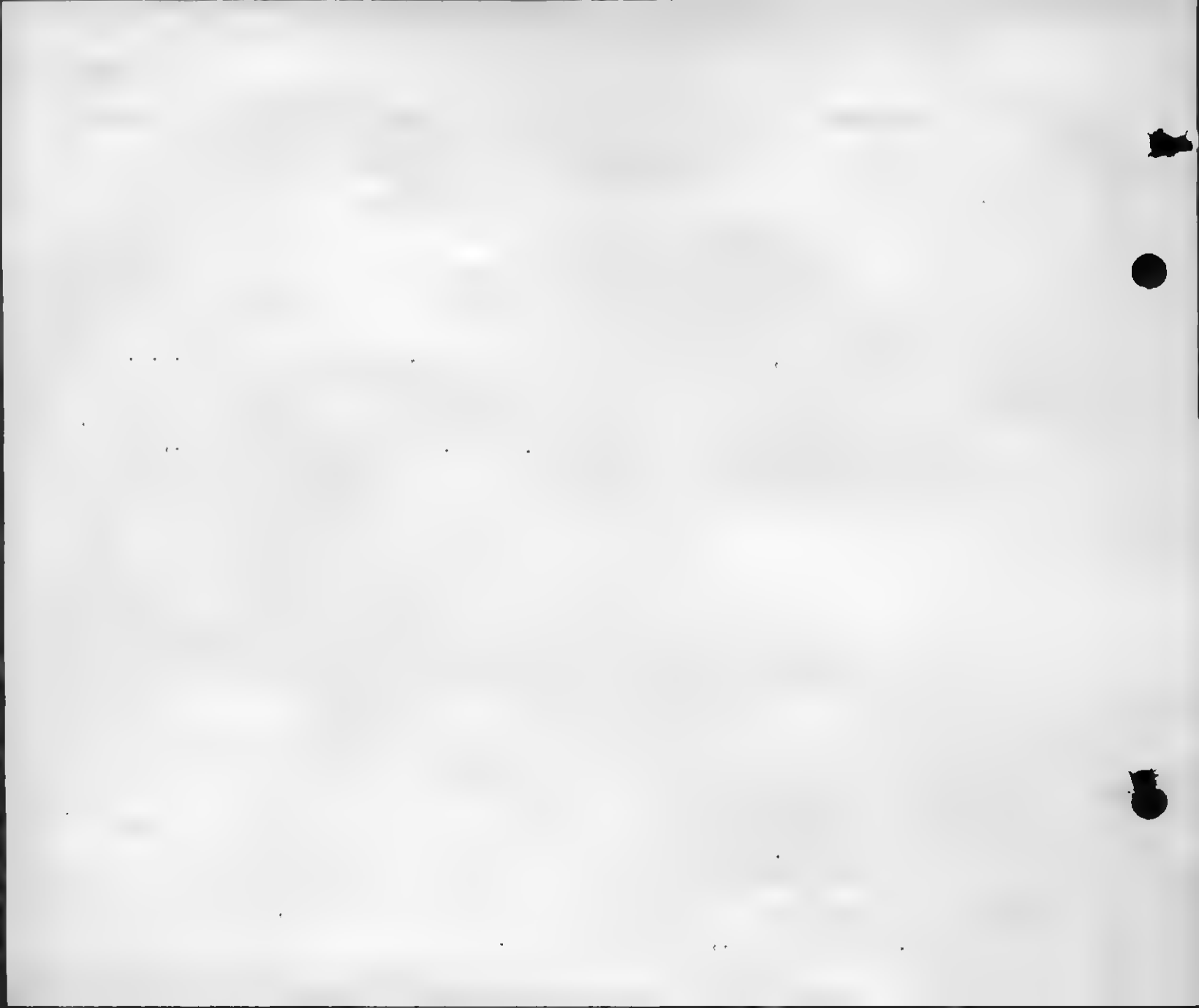
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6897

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06883

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY in 1b <b>6 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1601 MYRTLE ROAD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Res. date & nature of admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>1601 MYRTLE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HESTER JENNIE BECKER</b>		4. DATE OF DEATH <b>JUNE 24 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/29/1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HIGH SCHOOL TEACHER, retired TEACHING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CARLISLE, NEW YORK</b>	
13. FATHER'S NAME <b>DANIEL HUTTON</b>		14. MOTHER'S MAIDEN NAME <b>FELECIA FORBES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>676 03 5268</b> <b>NOT LOCATED</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute antero-lateral coronary artery</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>occlusion with myocardial infarction</b> DUE TO (c) <b>and congestive failure.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 1961</b> to <b>24 JUNE, 1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>24 June 1961</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Ernest E. Harmon</b>		22b. DATE SIGNED <b>JUNE 24, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>ERNEST E. HARMON</b>		22d. ADDRESS <b>9301 Cokesville Rd. Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6/27/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CARLISLE CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>CARLISLE, NEW YORK</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		25a. REC'D BY REGISTRAR <b>JUN 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harmon</b>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>List of Co.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>3900 Watson Pl. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Norman Bengston</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>male</u>		6. CO. OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> D. VORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/3/01</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scientific Inst. Illinois</u>	
11. BIRTHPLACE (County & State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles A. Bengston</u>		14. MOTHER'S MAIDEN NAME <u>Martha L. Lorton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Margaret E. Bengston</u>	
17. INFORMAT <u>Margaret E. Bengston</u>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial infarction</u> causing the underlying cause last. (c) <u>3-4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral infarction, right parietal lobe</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1955</u> to <u>June 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 11, 1961</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John E. Everett</u>		22b. DATE SIGNED <u>6/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		22d. ADDRESS <u>9400 Conn Ave Kensington Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6/14/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery Skokie, Illinois</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			



CERTIFICATE OF DEATH

Reg. Dist. No. 06885

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>7438 Baltimore</i>	
3. NAME OF DECEASED (Type or print) <i>Frieda. Johanna. Bohlmann.</i>		4. DATE OF DEATH Month <i>6</i> / Day <i>23</i> / Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/14/1891</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR: Months <i>10</i> Days <i>10</i> Hours <i>10</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Berlin, Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>Germany</i>	
13. FATHER'S NAME <i>Johann. Wilhelm. Culenfeldt</i>		14. MOTHER'S MAIDEN NAME <i>Emilie Elizabeth. Hoppe</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>John. Bohlmann</i>		Address <i>7438 Baltimore Takoma Park</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Coma -</i> <i>155.1</i> DUE TO <i>Cholecystitis of Gall Bladder.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>with metastases.</i> DUE TO (b) <i>Symptoms</i> (c) <i>6 1/2 Mo</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Surgery. 3/27/61 - as above found.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/24/1961</i> to <i>6/23/1961</i> , that I last saw the deceased alive on <i>6/23/1961</i> , and that death occurred at <i>10:58</i> M., from the causes and on the date stated above. F ADDRESS (Street, city or town, state) <i>7030 Carroll Ave</i> DATE SIGNED <i>6/23/61</i>			
ACTUAL SIGNATURE <i>Howard T. Morse</i> M.D.		PHYSICIAN'S NAME (Type) <i>Howard T. Morse</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 27, 1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St NW. D.C.</i>	
24a. REC'D BY REGISTRAR <i>DATE JUN 27 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

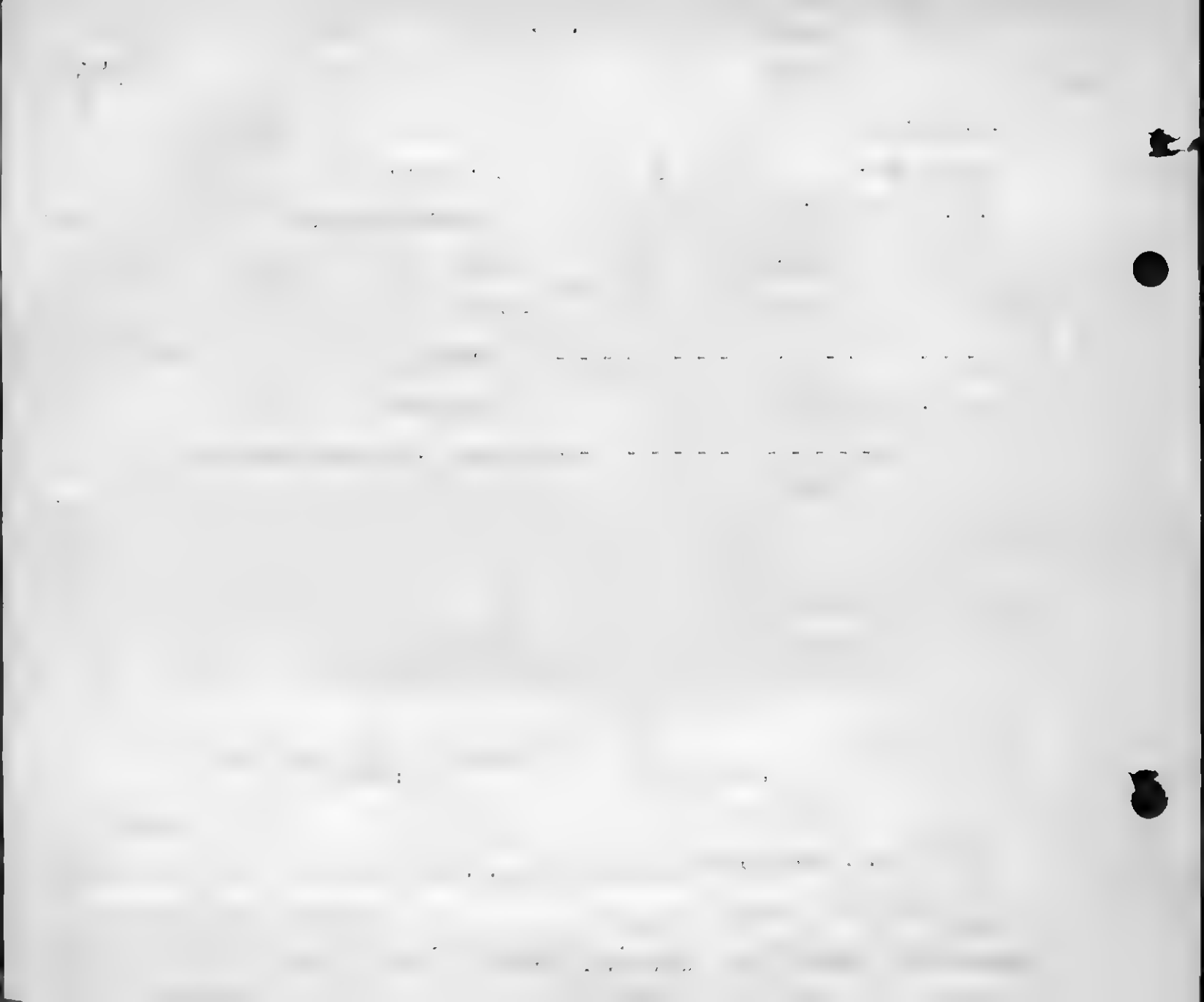
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6000

06886

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY in lb <b>10 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Texas</b>		b. COUNTY <b>Nueces</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Corpus Christi</b>		d. STREET ADDRESS <b>241 Military Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Byron Emory BOWLING</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-9-53</b>		9. AGE (In years last birthday) <b>8</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>23</b> Hours <b>19</b> Min.		11. IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Naval Hospital</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BOWLING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Donald E. BOWLING</b>		14. MOTHER'S MAIDEN NAME <b>Lena Boyles</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(F) Donald E. BOWLING</b>		17. INFORMANT <b>Same as # 2 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tetralogy of Fallot -</b> <b>7540</b> DUE TO Conditions, if a y, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Congenital Heart Disease -</b> (c) <b>Congenital</b> <b>18 years</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Interval between ONSET AND DEATH</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from <b>14 June</b> to <b>23 June</b> , 19 <b>61</b> , that (X) (we) last saw the deceased alive on <b>23 June</b> , 19 <b>61</b> , and that death occurred at <b>6:35 PM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>B.H. Rice</b>		22b. DATE SIGNED <b>6-24-61</b>		22c. PHYSICIAN'S NAME (Type) <b>B.H. RICE LT, MC, USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>		22e. REC'D BY REGISTRAR <b>DATE JUN 27 '61</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		23a. BUREL, CREMATION, 23b. DATE THEREOF <b>Burial - Shipment 6-25-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City, town or county) (State) <b>Bluefield, West Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		24a. ADDRESS <b>1331 E. Montgomery Ave. Rockville, Maryland</b>		24b. DATE <b>JUN 27 '61</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		24d. DATE <b>JUN 27 '61</b>		24e. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		24f. DATE <b>JUN 27 '61</b>		24g. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		24h. DATE <b>JUN 27 '61</b>			



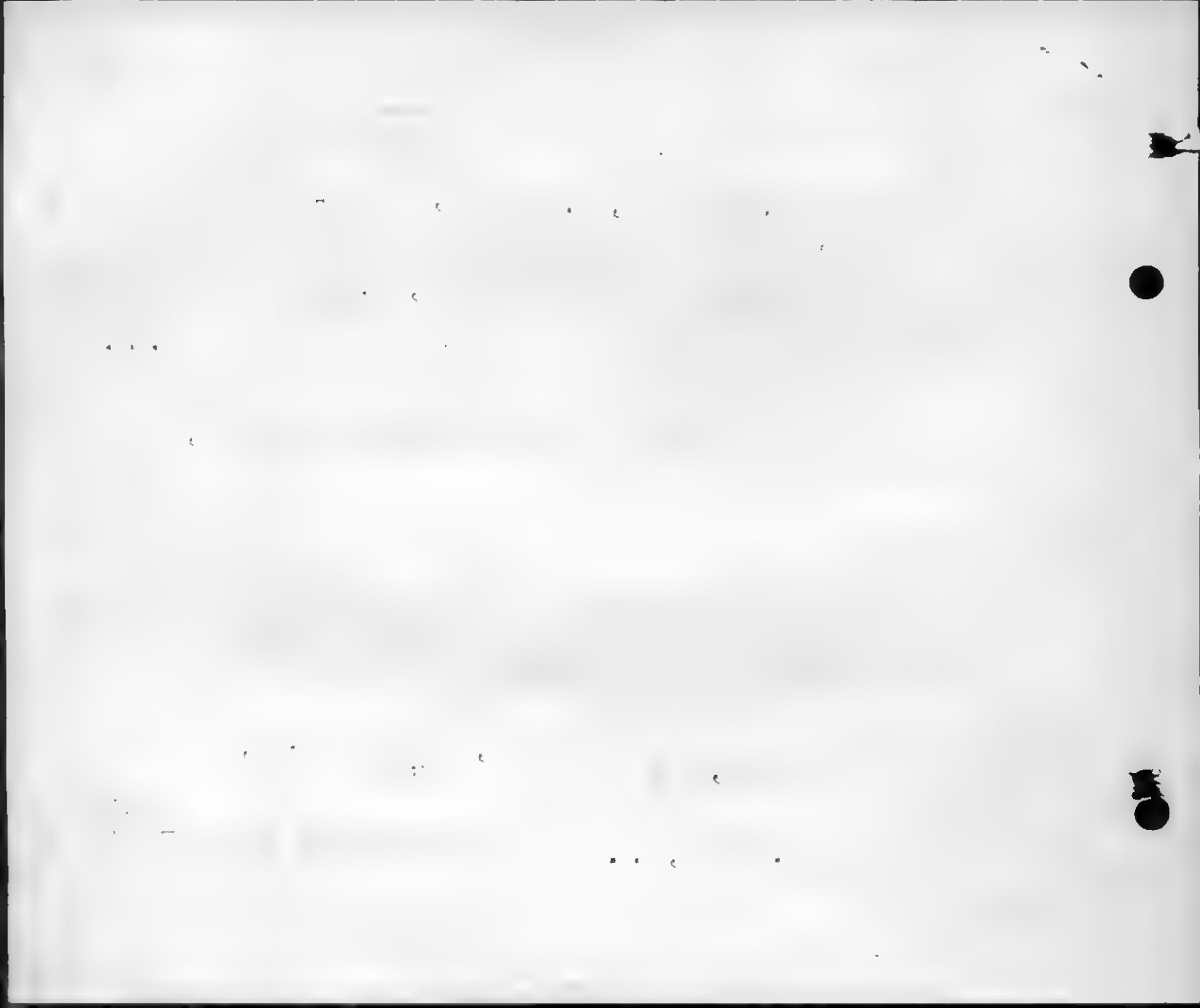
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06887

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>Tennessee</b> b. COUNTY <b>Bradley</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>17 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>Route #4, Box 251 - B</b>	
3. NAME OF DECEASED (Type or print) <b>Bryan Mark Brinkley</b>		4. DATE OF DEATH <b>June 11, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 30, 1959</b>
9. AGE (In years last birthday) yrs <b>1</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bobbie Brinkley</b>		14. MOTHER'S MAIDEN NAME <b>Lois Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Records</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>204.3 ACUTE LYMPHOBLASTIC LEUKEMIA</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 25, 1961</b> to <b>June 11, 1961</b> that (I) (we) last saw the deceased alive on <b>June 11, 1961</b> and that death occurred at <b>2:00 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>EMANUEL S. HELLMAN, M.D.</b>		22b. ADDRESS <b>The Clinical Center Bethesda 14, National Institutes Of Health Maryland</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<b>Burial-transit 6-12-61</b>		<b>Moore's Chapel Cemetery Cleveland, Tenn.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>JUN 16 '61</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. The attending physician or attending funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
6902  
CERTIFICATE OF DEATH  
06888

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>500 W. Montgomery Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Josephine B. Brooks</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> , Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 6, 1880</b>	
9. AGE (In years last birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b>	
11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>19</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Connecticut</b>	
13. FATHER'S NAME <b>George H. Day</b>		14. MOTHER'S MAIDEN NAME <b>Katharine Beach</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Martin Bennett-Son</b>		Address <b>Alexandria, Va</b> <b>3201 Burgundy Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis generalized</b> DUE TO (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelonephritis</b> <b>Bronchopneumonia</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>None</b>	
21. I certify that (I) (the hospital) attended the deceased from <b>Sept. 1959</b> to <b>May 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 11, 1961</b> , and that death occurred at <b>2:55 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>George Sharpe</b>		22b. DATE SIGNED <b>6/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>George Sharpe</b>		22d. ADDRESS <b>10511 Sumit Ave. Kensington, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>5/13/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 14 '61</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



Page 1  
In 24 hours after death  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

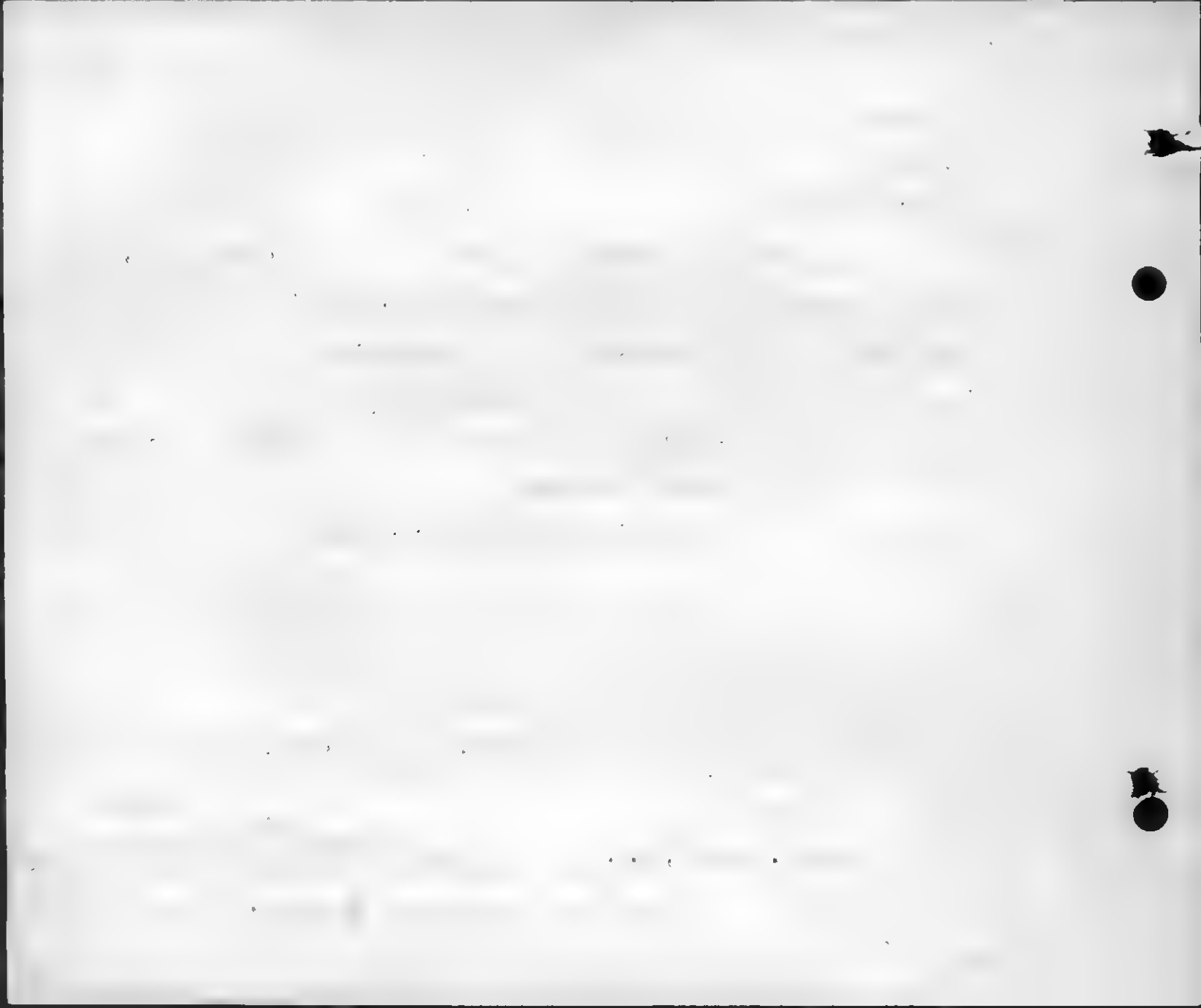
(M)

(I)

6903  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06889

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>16 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sarver</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>			d. STREET ADDRESS <b>R. D. # 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RAY</b> Middle <b>HENRY</b> Last <b>BRYAN</b>			4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 25, 1913 47</b>		9. AGE (In years last birthday) <b>47 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Cale Saylor</b>		
14. MOTHER'S MAIDEN NAME <b>Pearl Bryan</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO <b>unavailable</b>			17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 4432 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>16 hours</b> <b>11 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from <b>May 24, 1961</b> to <b>June 9, 1961</b> , that (we) last saw the deceased alive on <b>June 9, 1961</b> and that death occurred at <b>8:00AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas E. Gaffney</i> M.D.			22b. DATE SIGNED <b>6/9/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Thomas E. Gaffney, M.D.</b>			22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>		
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JARVISVILLE CEMETERY</b>	
23d. LOCATION (City, town, or county) <b>Bethesda Township P.A.</b>		23e. LOCATION (State) <b>P.A.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>			25a. REC'D BY REGISTRAR <b>JUN 12 '61</b>		
25b. REGISTRAR'S SIGNATURE <i>Robert A. Humphrey</i>			25c. DATE <b>JUN 12 '61</b>		





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY STATE EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6904

06890

1. PLACE OF DEATH COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b> COUNTY <b>Prince George</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lewisdale</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>				d. STREET ADDRESS <b>2201 Lewisdale Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Dorothy Helen Budzianowski</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OF RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 13, 1916</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Manchester New Hampshire</b>	
13. FATHER'S NAME <b>Roger Crowley</b>				14. MOTHER'S MAIDEN NAME <b>Mary O'Malley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Navy 1942-47</b>				16. SOCIAL SECURITY NO. <b>Washington Sanitarium &amp; Hospital Records</b>			
17. INFORMANT <b>Washington Sanitarium &amp; Hospital Records</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>420.1</b>				DUE TO <b>Coronary occlusion</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Brochert</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROCHERT</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Buried</b>				22b. DATE THEREOF <b>June 7, 1961</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Arlington Va.</b>			
23. FUNERAL DIRECTOR <b>John W. ...</b>				24a. REC'D BY REGISTRAR <b>JUN 7 '61</b>			
ADDRESS <b>254 Carroll St. N.W. Wash. D.C.</b>				24b. REGISTRAR'S SIGNATURE <b>Charles S. ...</b>			

M

I

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

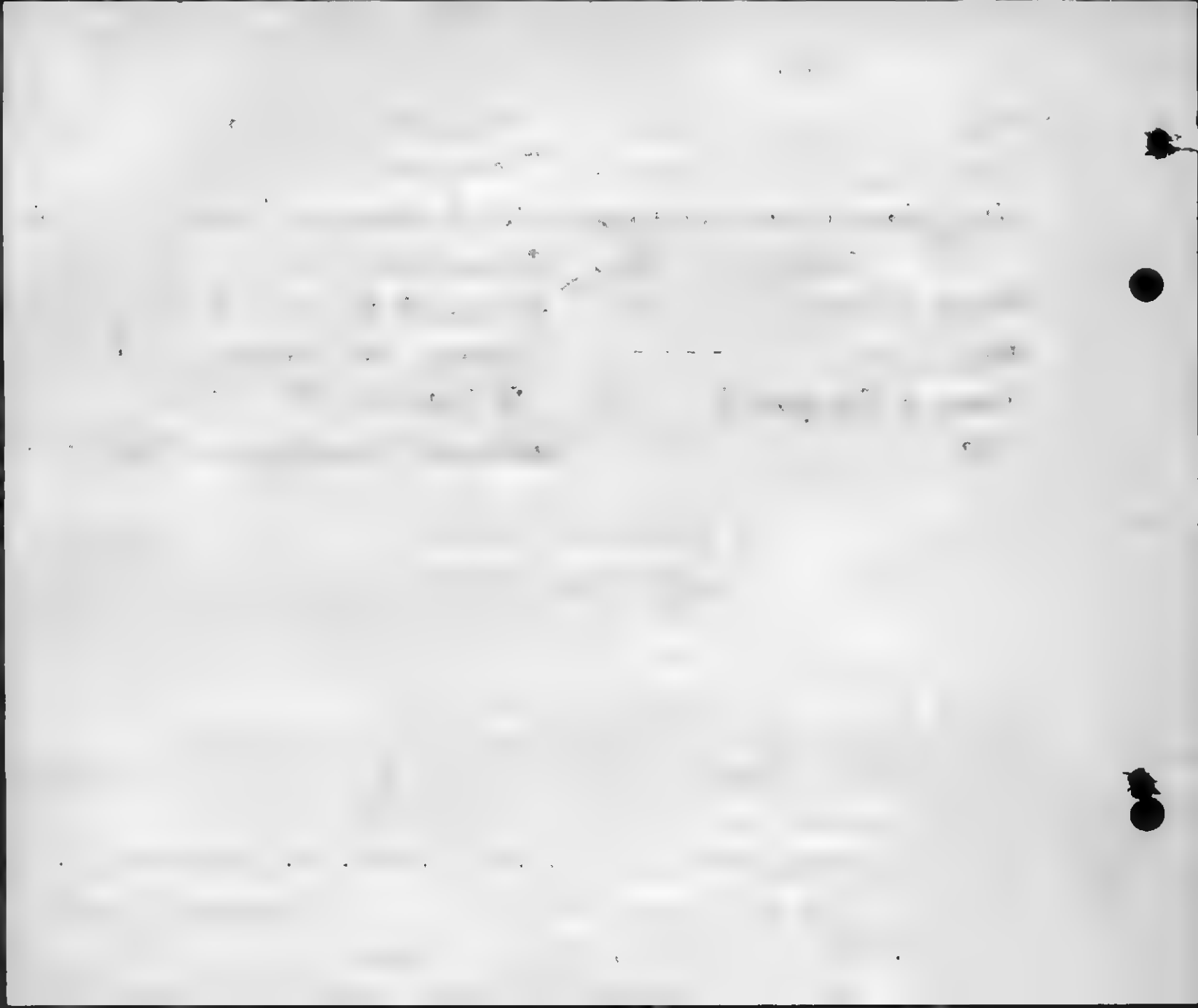
6905

68891

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>					
3. NAME OF DECEASED (Type or print) <b>Jessie Mae Campbell</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1961</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Month <b>January</b> Day <b>19</b> Year <b>1891</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (Country & State, or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Robert Campbell</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Fowler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Washington Sanitarium and Hospital Records</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>					
DUE TO (b) <b>Cerebro-Vascular Accident</b>					
DUE TO (c) <b>Hypertensive Heart Disease</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 1957</b> to <b>June 30, 1961</b> , that (I) <del>two</del> <b>one</b> saw the deceased alive on <b>June 29, 1961</b> , and that death occurred at <b>12 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Ernest A. Sarao</b>		22b. DATE SIGNED <b>June 30, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Ernest A. Sarao</b>	
22d. ADDRESS <b>M.D. 7006 N. Hamp. Ave. Takoma Park, Md.</b>		22e. REC'D BY REGISTRAR <b>DATE JUL 3 '61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/3/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
23d. LOCATION (City, town or county) <b>Prince Georges</b>		(State) <b>Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>					
ADDRESS <b>Bethesda, Maryland</b>					
25a. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>					

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Ella pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Items 14 & 15  
6-27-61  
6906  
MONTGOMERY, MARYLAND  
TAKOMT PARK W.O.A.  
99 Wash. St. Hosp.  
Richard Earl Carson  
M W  
1-13-92  
Mg. Sinclear  
Thomas Edward Carson  
Tirzah L. Donaldson  
216-05-2567  
MRS. Richard Carson Jr.  
900.0  
MULTIPLE FRACTURES OF THE SKULL  
MYOCARDIAL INFARCTION WITH CARDIAC ENLARGEMENT AND CONGESTIVE FAILURE  
MARKEDLY SEVERE CORONARY ARTERIOSCLEROSIS  
7:30 p.m. 6-13-61  
home Silver Spring Montg Md  
Frank J. Broschert  
FRANK J. Broschert  
6-14-61  
6/16/61  
Arlington Nat. Cemetery Arlington, Virginia  
Wash, D.C.  
JUN 15 61  
Arthur L. Thomas

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TAKOMT PARK W.O.A.  
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Richard Earl Carson  
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6-14-61  
6/16/61  
Arlington Nat. Cemetery Arlington, Virginia  
Wash, D.C.  
JUN 15 61  
Arthur L. Thomas

1. PLACE OF DEATH  
a. COUNTY  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  
c. LENGTH OF STAY IN TB  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  
2. USUAL RESIDENCE (where deceased lived, if institution, Residence before admission)  
a. STATE  
b. COUNTY  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  
d. STREET ADDRESS  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒  
3. NAME OF DECEASED (Type or print)  
First Middle Last  
4. DATE OF DEATH  
Month Day Year  
5. SEX  
6. COLOR OR RACE  
7. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH  
Month Day Year  
9. AGE (in years last birthday)  
IF UNDER 1 YEAR Months Days  
IF UNDER 24 HRS Hours Min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
10b. KIND OF BUSINESS OR INDUSTRY  
11. BIRTHPLACE (State or foreign country)  
12. CITIZEN OF WHAT COUNTRY?  
13. FATHER'S NAME  
14. MOTHER'S MAIDEN NAME  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  
16. SOCIAL SECURITY NO.  
17. INFORMANT Address  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) DUE TO  
(c) DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m.  
20d. INJURY OCCURRED While at work ☐ Not While at work ☒  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)  
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒  
Address (Street, city, town, or county)  
22a. BURIAL, CREMATION, REMOVAL (Specify)  
22b. DATE THEREOF  
22c. NAME OF CEMETERY OR CREMATORY  
22d. LOCATION (City, town, or country) (State)  
23. FUNERAL DIRECTOR ADDRESS  
24a. REC'D BY REGISTRAR  
24b. REGISTRAR'S SIGNATURE

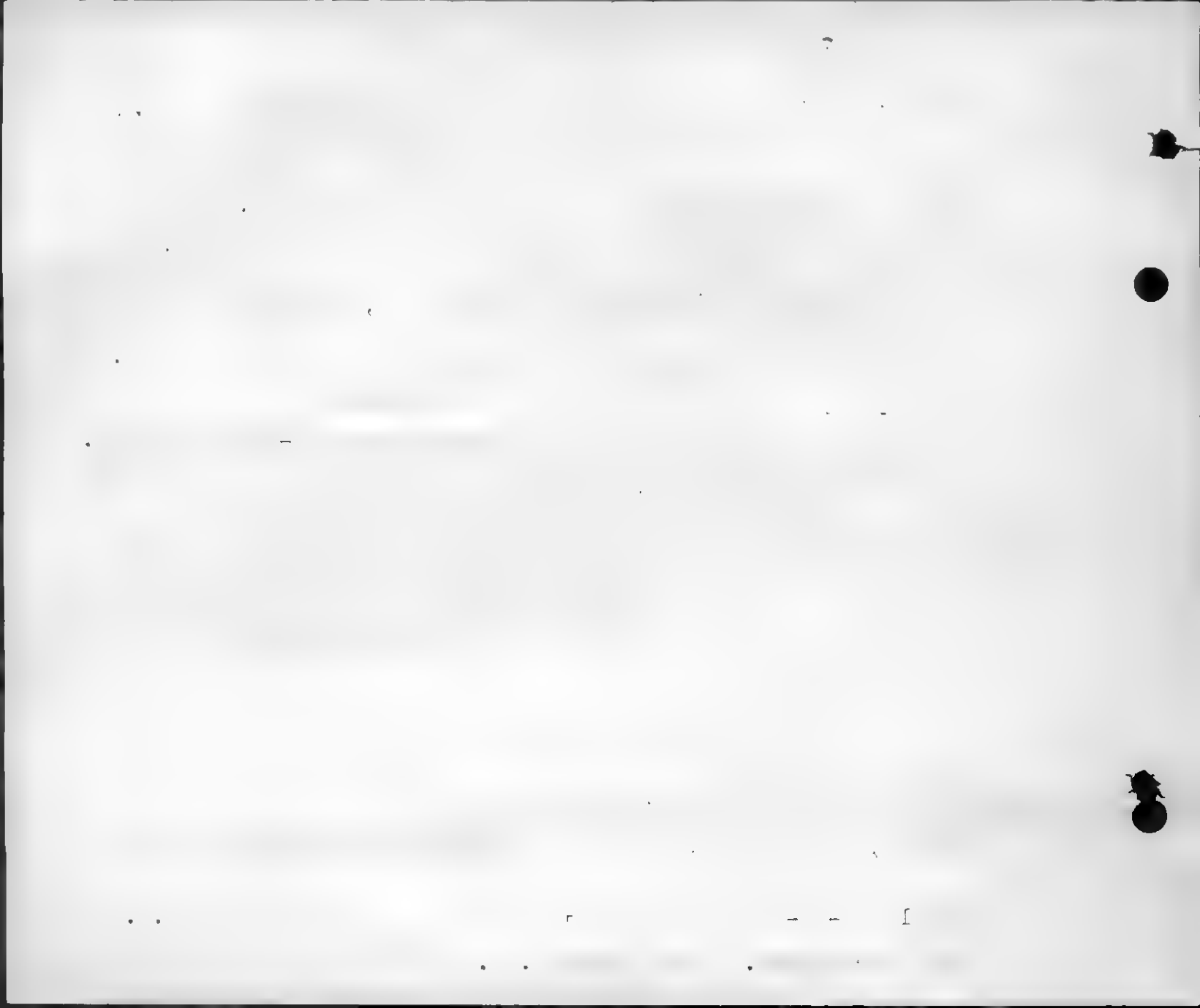


TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

(M)

(I)

<div style="display: flex; justify-content: space-between;"> <span>6907</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</span> <span>06893</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 years</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Bardens Sanitarium</b>				d. STREET ADDRESS <b>6116 Westchester Dr.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary Josephine Casson</b>				4. DATE OF DEATH <b>June 8 1961</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 20, 1864</b>		9. AGE (In years last birthday) <b>96<sup>rs</sup></b>		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Wood</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs Edna Naughton -same as above.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: <b>428.1</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary Artery Disease,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>Heart Block</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day Year Hour <b>0:00</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 159</b> to <b>June 8 1961</b> , that (I) (we) lost <b>saw the deceased alive on June 6 1961</b> , and that death occurred at <b>9:10 p.m.</b> from the causes and on the date stated above											
22a. SIGNATURE <b>Robert T. Thibadeau</b>						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>June 8, 1961</b>			
22c. PHYSICIAN'S <b>Robert T/ Thibadeau, M.D.</b>						22d. ADDRESS <b>10609 Concord St., Kensington, Md.</b>					
23a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home.</b>						ADDRESS <b>Washington D. C.</b>		25a. REC'D BY REGISTRAR <b>JUN 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	




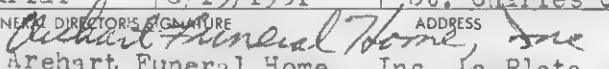



may be retained in the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

C908

06894

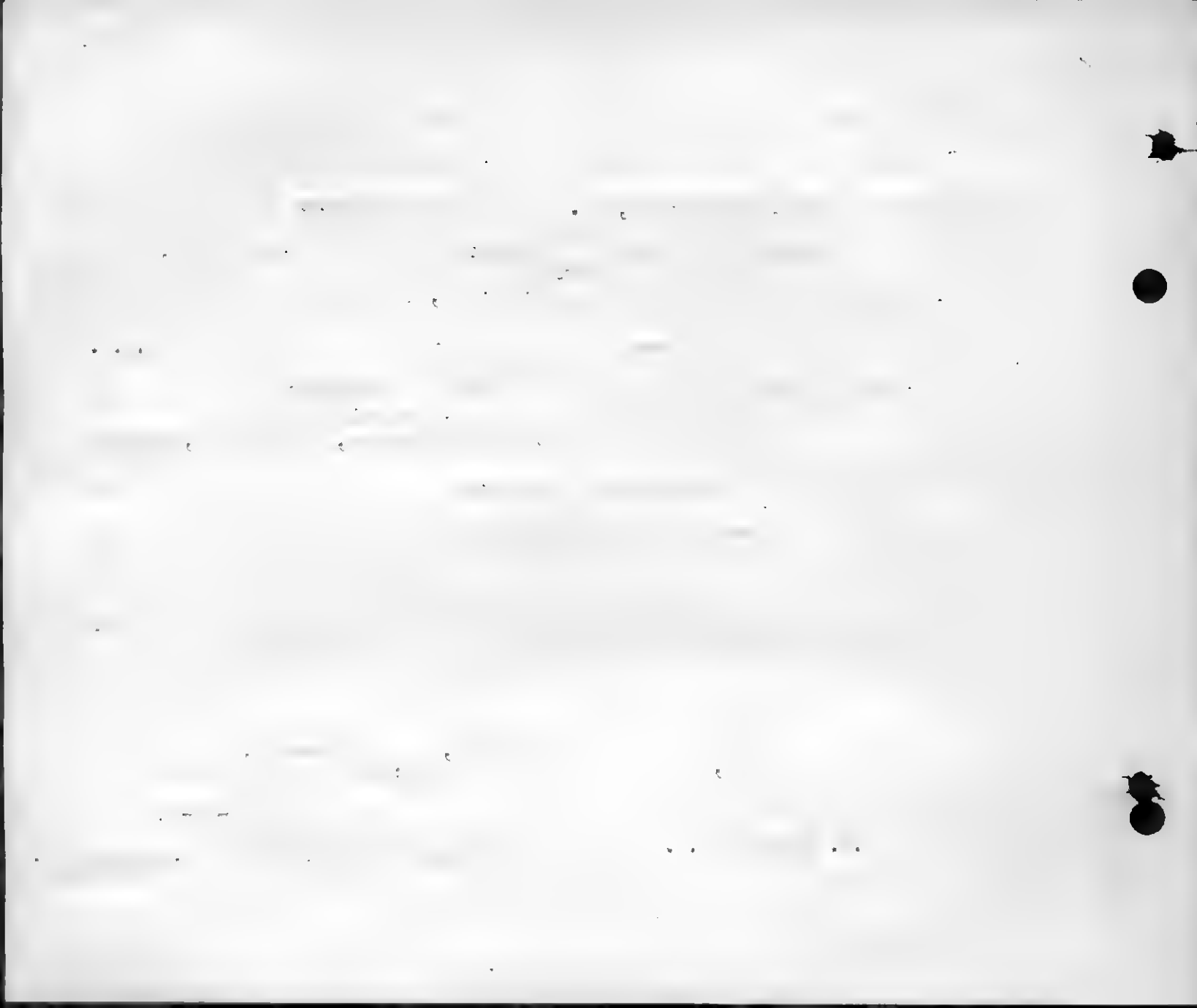
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>43 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. STREET ADDRESS <b>110 Circle Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Melanie</b> Middle <b>Gaye</b> Last <b>Cather</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10,</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 12, 1955</b>
9. AGE (In years lost birthday) yrs. <b>5</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Cather</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Sutherland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. <b>204.3</b> IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Acute Lymphatic Leukemia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b> <b>1 Year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 29, 1961</b> to <b>June 10, 1961</b> that (I) (we) last saw the deceased alive on <b>June 10, 1961</b> and that death occurred at <b>11:50AM</b> from the causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>6-11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>E.S. Hellman M.D.</b>		22d. ADDRESS <b>The Clinical Center National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/13/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Church Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Glymont, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE  <b>Archart Funeral Home, Inc., La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 16 '61</b>	
		25b. REGISTRAR'S SIGNATURE 	

(M)

(I)

V

MEDICAL CERTIFICATION

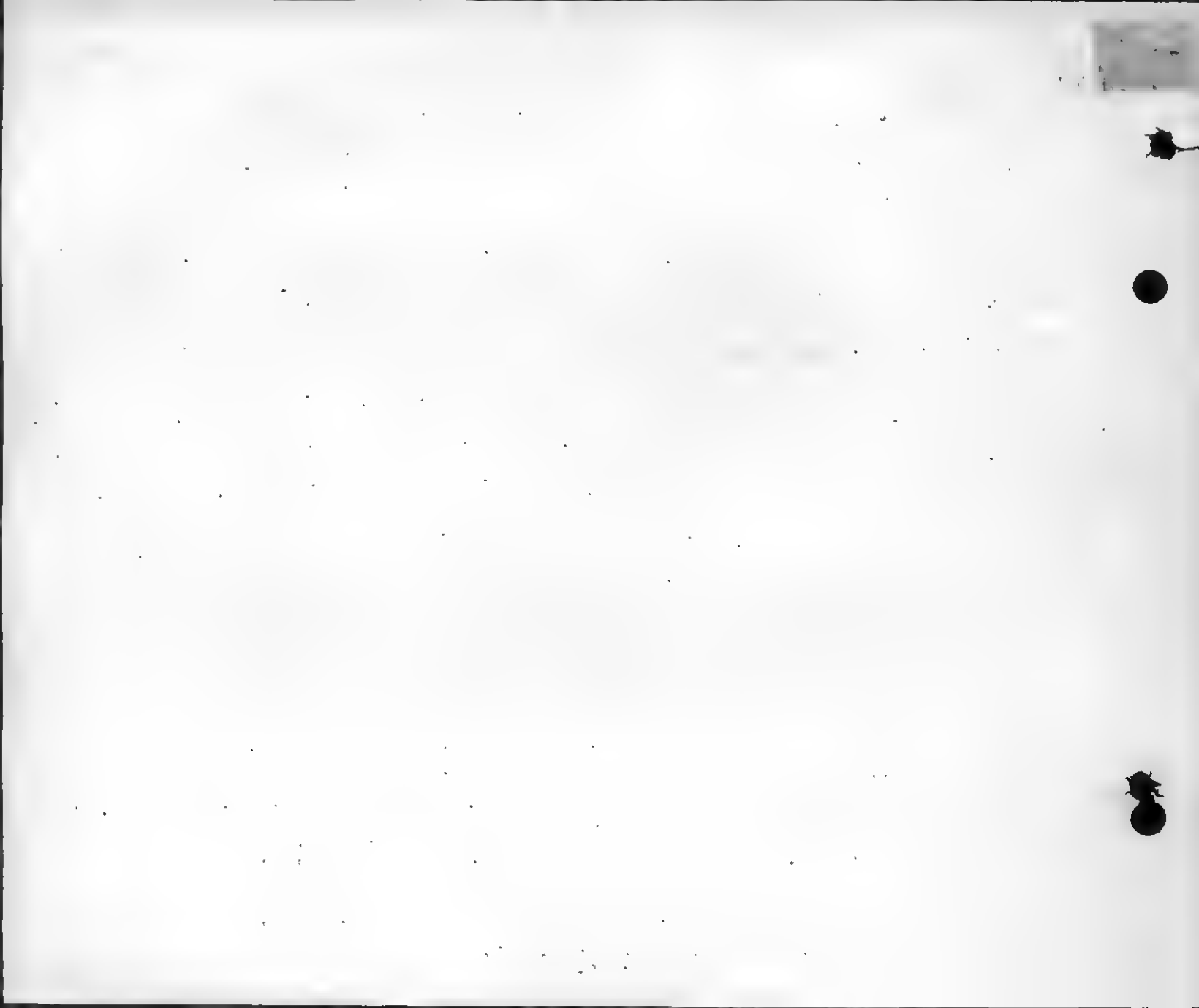


6910

## CERTIFICATE OF DEATH

Reg. Dist. No. 06897

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Colesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mary Lee Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>C.</u> Last <u>Cissel</u>				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/76</u>		9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wilbur F. Cissel</u>				14. MOTHER'S MAIDEN NAME <u>Clara Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-8868</u>		INFORMANT <u>Mrs Dorothy Lehnkull</u> Address <u>109 Belvedere Blvd Silver Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Accidental Torsion Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>4 days</u> (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 one</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1, 1957</u> to <u>June 27, 1961</u> , that I last saw the deceased alive on <u>June 26, 1961</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.				ADDRESS (Street, city or town, state) <u>1919 Seminary Rd. - Silver Spring Md.</u> DATE SIGNED <u>6-27-61</u>			
PHYSICIAN'S NAME (Type) <u>John S. Rogers</u>				1919 Seminary Rd., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		22d. LOCATION (City, town, or county) (State) <u>Highland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Rogers</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6909 CERTIFICATE OF DEATH 66895											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Woods (Rockville)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospice, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4414 Ives Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARTIN</u> First <u>Thomas</u> Middle <u>Chilcont</u> Last <u>Chilcont</u>				4. DATE OF DEATH <u>June 8 1961</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>February 17 1961</u>			
9. AGE (In years last birthday) <u>3</u> yrs. <u>22</u> Months <u>3</u> Days <u>22</u>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>Thomas Melvin Chilcont</u>			
14. MOTHER'S MAIDEN NAME <u>Irene E. Bartkovich</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>(Father) Thomas Chilcont</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>471X</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Patient ductus arteriosus, Atrial septal defect, Hypertrophy of left ventricle</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>											
20c. TIME OF INJURY Month, Day, Year <u>4-7</u> 19 <u>61</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) <u>Rockville, Md.</u> (County) <u>Montgomery</u> (State) <u>Md.</u>											
21. I certify that (I) (this hospital) attended the deceased from <u>2-17</u> , 19 <u>61</u> , to <u>4-7</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4-7</u> , 19 <u>61</u> , and that death occurred at <u>10AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Carl Silverman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>June 8, 1961</u>											
22c. PHYSICIAN'S NAME (Type) <u>Carl Silverman</u> 22d. ADDRESS <u>12801 Evanston St. Rockville, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>June 9, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> 23d. LOCATION (City, town or county) <u>Rock Montgomery County, Md.</u> (State) <u>Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., 8434 Georgia Ave., Silver Spring, Md.</u> 25a. REC'D BY REGISTRAR <u>June 12 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>											

1111111111



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

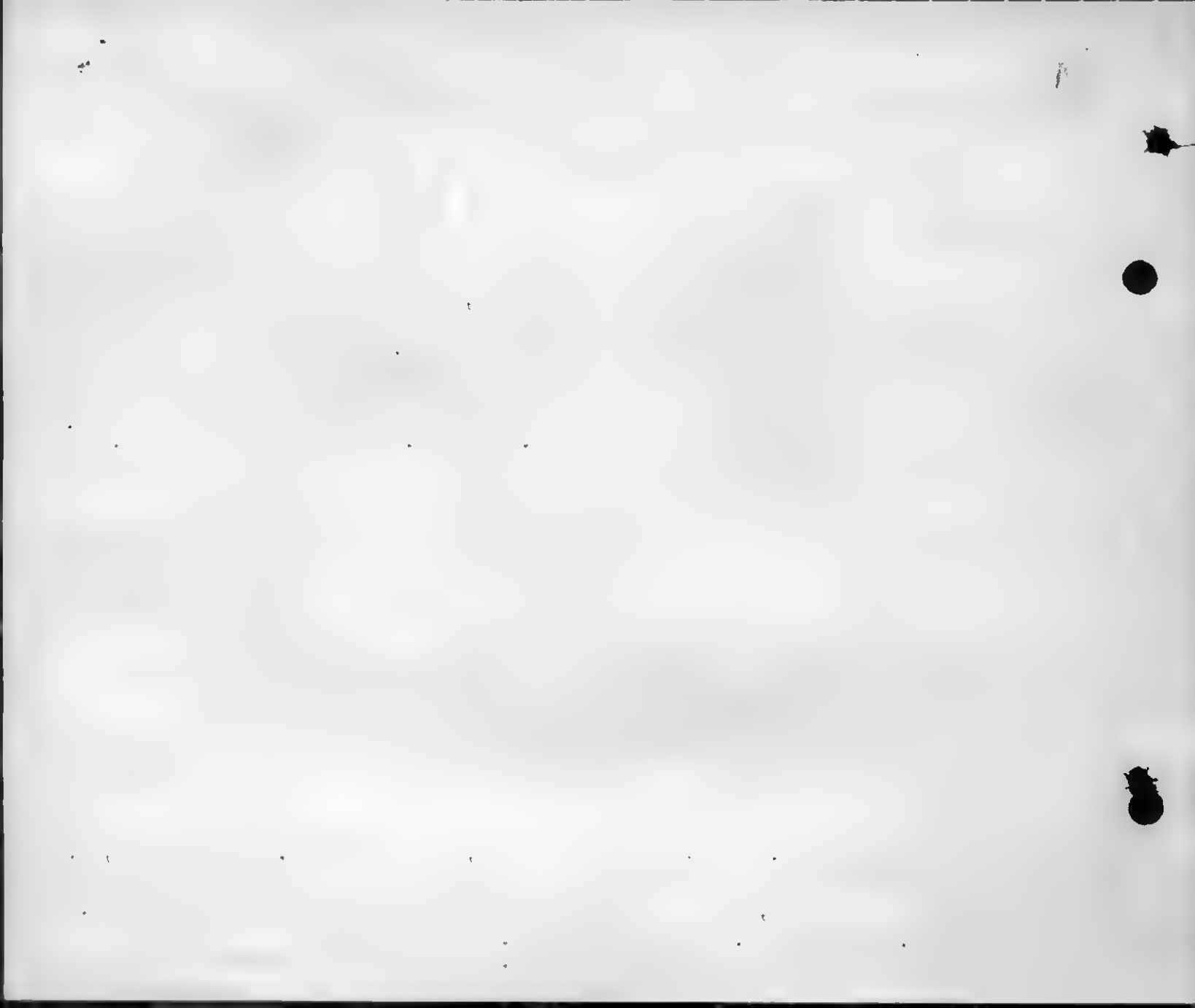
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6911

## CERTIFICATE OF DEATH

06898

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> c. LENGTH OF STAY in b <b>2 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1213 BROADWOOD DRIVE</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> d. STREET ADDRESS <b>1213 BROADWOOD DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ELIZABETH</b> First Middle Last <b>CLISER</b>		<b>4. DATE OF DEATH</b> Month <b>JUNE</b> Day <b>2</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>OCT 6, 1894</b>	
<b>9. AGE</b> (In years last birthday) <b>66</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>6</b> Days <b>1</b>	
<b>11. IF UNDER 24 HRS.</b> Hours <b>1</b> Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN HOME</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>PAGE CO. VIRGINIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>WILLIAM JEWELL</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>BERTIE SMELSER</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <b>Mr. Oliver J. Cliser</b>		<b>1213 Broadwood Dr. Rockville Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>IX</b> DUE TO <b>Carcinoma stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO <b>with metastases</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days - 6 mos</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)			
<b>20c. TIME OF INJURY</b> Hour <b>19</b> a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from 1/5/61, 19, to 6/2/61, 19, that (I) (we) last saw the deceased alive on 6/2/61, 19, and that death occurred at 10 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Patrick C. Jameson M.D.</b>		<b>22b. DATE SIGNED</b> <b>6/2/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Patrick C. Jameson</b>		<b>22d. ADDRESS</b> <b>12,020 Georgia Ave. Silver Spring, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>June 7, 1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fort Lincoln Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Prince George County Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Warner E. Pulapirey, Inc.</b>		<b>25a. REC'D BY REGISTRAR</b>	
<b>4834 Georgia Ave. Silver Spring Md.</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE JUN 9 '61</b>	





**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

0912

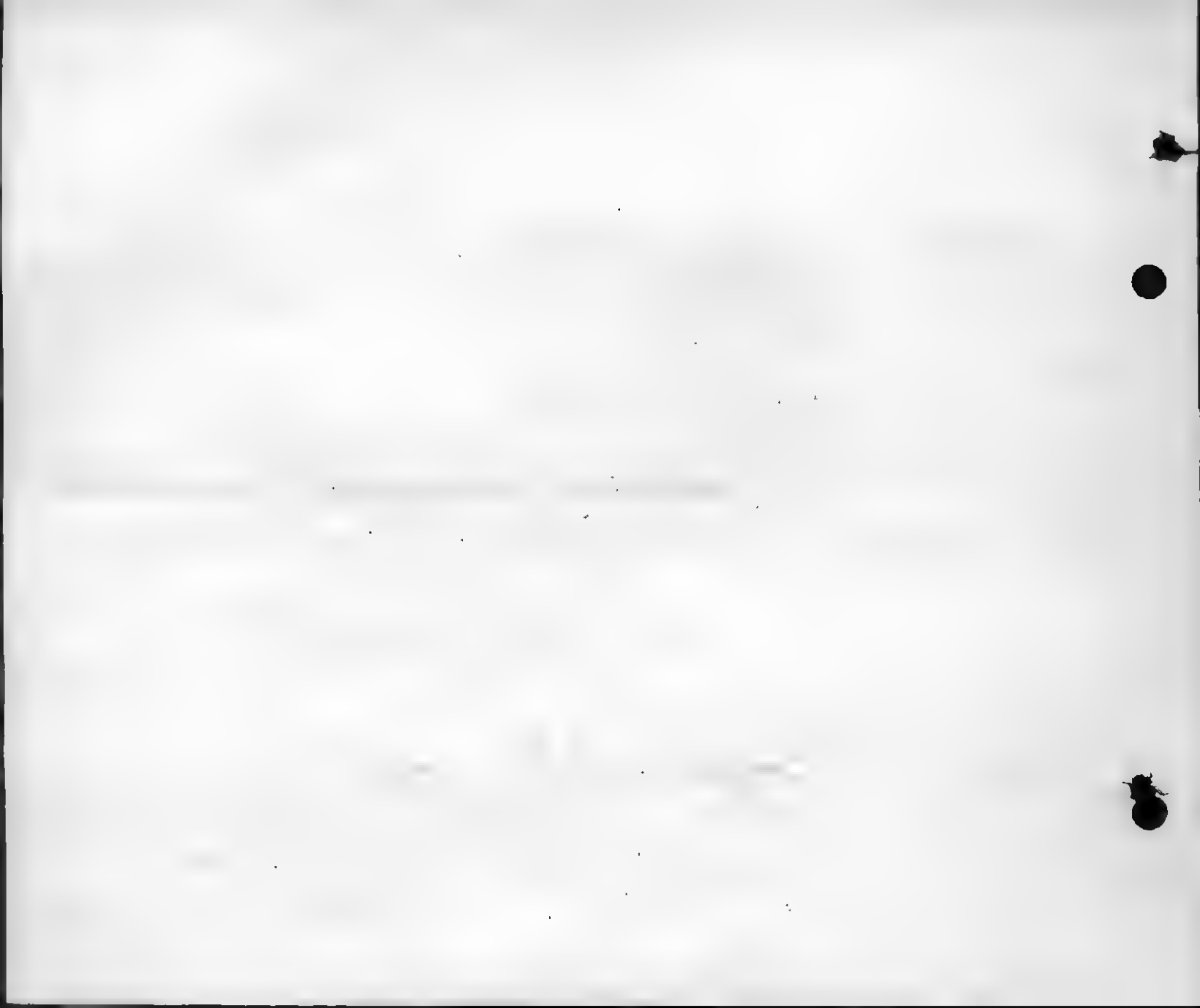
06899

1. PLACE OF DEATH a. COUNTY <i>Montg.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montg.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Laurel</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tahoma Park</i>	
c. LENGTH OF STAY IN 1b <i>47 days</i>		d. STREET ADDRESS <i>106 Elm Ave.</i>	
e. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cortland Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Albert</i> Middle <i>Valentine</i> Last <i>Cobb</i>		4. DATE OF DEATH Month <i>6</i> Day <i>11</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 2, 1880</i>
9. AGE (In years last birthday) <i>81</i> yrs		10. UNDER 1 YEAR Months <i>8</i> Days <i>1</i> Hours <i>1</i> Min <i>0</i>	11. UNDER 24 HRS Months <i>8</i> Days <i>1</i> Hours <i>1</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Windsor N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Albert Valentine Cobb</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Sharrock</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Wm. A. Gocherour</i>		18. ADDRESS <i>1015 Elm Ave Tahoma Park Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>broncho pneumonia</i> DUE TO (b) <i>Gen. arteriosclerosis</i> DUE TO (c) <i>Senile Dementia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <i>6</i> Day <i>11</i> Year <i>1961</i> Hour <i>a. m.</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6/4/61</i> to <i>6/11/61</i> , that (I) (we) last saw the deceased alive on <i>6/11/61</i> , and that death occurred at <i>6:25</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>H. T. Morse</i>		22b. DATE <i>6/11/61</i> SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>H. T. Morse</i>		22d. ADDRESS <i>7030 Carroll Ave Tahoma Park, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>June 14, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Edgewood Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Windsor, North Carolina</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>254 Carroll Ave</i>	
25b. REGISTRAR'S SIGNATURE <i>Walters &amp; Thomas</i>		DATE <i>JUN 13 '61</i>	

MEDICAL CERTIFICATION







TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06901

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>59 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Ann Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>1000 Madison Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ethel Gertrude CONDYLES</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-3-96</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>South Carolina</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John K. BLACKWELL</b>		14. MOTHER'S MAIDEN NAME <b>Rhoda HENDERSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>(S) Eugene G. Condyle, same as #2 above</b>	
17. INFORMANT <b>(S) Eugene G. Condyle, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal shutdown with uremia</b> DUE TO (b) <b>Carcinoma of the cervix</b> DUE TO (c) <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 24, 19 61</b> to <b>June 22, 19 61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 22, 19 61</b> , and that death occurred at <b>3:20AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur O. Anctil, Jr.</b>		22b. DATE SIGNED <b>6-22-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arthur O. ANCTIL, JR., MC, LT, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-24-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Richmond Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. W. Bliley, 3rd &amp; Marshall Sts., Richmond, Va.</b>		25a. REC'D BY REGISTRAR <b>JUN 26 '61</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6915

06902

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> Montgomery				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if instit on. Residence before admission) <b>a. STATE</b> Maryland			
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) Barstow P.O., Calvert Co.			
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) U. S. Naval Hospital				<b>d. STREET ADDRESS</b> - - - - -			
<b>3. NAME OF DECEASED</b> (Type or print) Mamie				<b>4. DATE OF DEATH</b> June 22 19 61			
<b>5. SEX</b> Female				<b>6. COLOR OR RACE</b> Caucasian			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> 8-11-86			
<b>9. AGE</b> (In years, last birthday) 74 yrs.				<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> - - - - -			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) Maryland				<b>12. CITIZEN OF WHAT COUNTRY?</b> USA			
<b>13. FATHER'S NAME</b> Morris SUITE				<b>14. MOTHER'S MAIDEN NAME</b> Rosie WILLIAMS			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No				<b>16. SOCIAL SECURITY NO.</b> None			
<b>17. INFORMANT</b> Mrs. Evelyn Black (D), same as #2 above				<b>Address</b> - - - - -			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Penal shutdown with uremia</i> (b) <i>Carcinoma of the cervix</i> (c)				<b>INTERVAL BETWEEN ONSET AND DEATH</b> 2 yrs.			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour o.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>May 9</i> <i>6:35AM</i> to <i>June 22</i> , 19 <i>61</i> , that <i>(X)</i> (we) last saw the deceased alive on <i>June 22</i> , 19 <i>61</i> , and that death occurred at <i>MD</i> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>Arthur O. Anctil, Jr.</i>				<b>22b. DATE SIGNED</b> 6-22-61		<b>22c. PHYSICIAN'S NAME</b> (Type) Arthur O. ANCTIL, JR., LT, MC, USN	
<b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b> REMOVAL (Specify) Burial June 24, 1961				<b>23c. NAME OF CEMETERY OR CREMATORY</b> Asbury Cemetery			
<b>23d. LOCATION</b> (City, town or county) (State) Barstow Maryland				<b>25a. REC'D BY REGISTRAR</b> DATE JUN 27 '61			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Harkness Funeral Home, Mutual, Md.				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Harkness</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.









# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6917

## CERTIFICATE OF DEATH

Reg. Dist. No. 06804

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>	
c. LENGTH OF STAY IN 1b <u>75 yrs.</u>		d. STREET ADDRESS <u>—</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ober</u> Middle <u>William</u> Last <u>DAILEY</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 10, 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew J. Dailey</u>		14. MOTHER'S MAIDEN NAME <u>Savilla Nicholson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-34-8041</u>	
17. INFORMANT <u>Mrs. Nellie Howes - daughter - Brookeville, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Cor Pulmonale</u> DUE TO (c) <u>Chronic Pulmonary Fibrosis + Emphysema</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>Arteric Aneurysm.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-6 hrs.</u> <u>years.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>June</u> , 1961, that I last saw the deceased alive on <u>June 13</u> , 1961, and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Yates MD</u>		ADDRESS (Street, city or town, state) <u>OLNEY Md</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. YATES</u>		DATE SIGNED <u>6-13-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-15-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brookeville</u>		22d. LOCATION (City, town, or county) (State) <u>Brookeville, Mont. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6613

66905

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> d. STREET ADDRESS <u>Pine Ridge Road</u>	
3. NAME OF DECEASED (Type or print) <u>Archie R. Daniels</u> First Last Middle 4. DATE OF DEATH <u>6-19-1961</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23 - 1901</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	9. AGE (in years last birthday) <u>60</u> yrs IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
11. FATHER'S NAME <u>HORACE DANIEL'S</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. MOTHER'S M maiden name <u>Mary Mac Namey</u>		14. SOCIAL SECURITY NO. <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. INFORMANT <u>Patient</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary failure</u> DUE TO (b) <u>Arteriosclerosis heart disease, Myocardial infarction</u> DUE TO (c) <u>Cause of Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Two days</u> <u>Two days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	22b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	22d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/19/1961</u> to <u>6/20/1961</u> , that (I) (we) last saw the deceased alive on <u>6/19/1961</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas H Wolohan</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolohan</u>		22d. ADDRESS <u>7600 Benell Ave Takoma Park</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial June 23, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>	
23d. LOCATION (City, town or county) <u>Beltville, Md.</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gerscho Son</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
ADDRESS <u>4739 3rd Ave. Hyattsville, Md.</u>		DATE <u>JUN 23 '61</u>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be retained by the hospital or funeral home for 24 hours after death. Page 4 must be retained by the hospital or funeral home. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

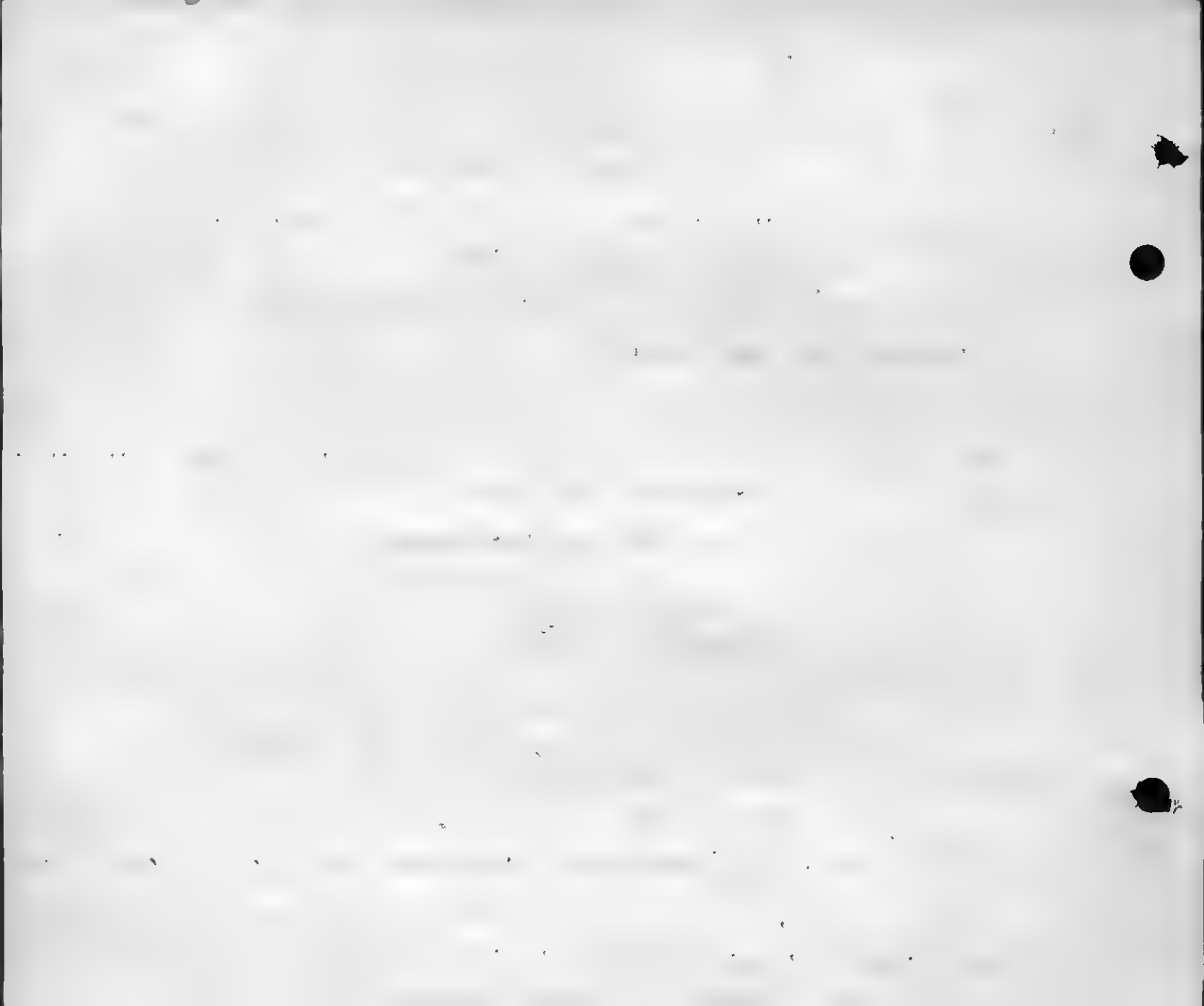
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6919

06906

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>2 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8714 CAMERON STREET., APT. #208</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>8714 CAMERON STREET, APT. #208</b>	
3. NAME OF DECEASED (Type or print) <b>CLIFFORD Norton DAVIS</b> First Middle Last 4. DATE OF DEATH <b>JUNE 17 1961</b> Month Day Year		e. IS RESIDENCE ON A FARM? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 23, 1893</b> 9. AGE (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED - RAILROAD ENGINEER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Maine</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Horace Davis</b>		14. MOTHER'S M.A.DEN NAME <b>Maude Norton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW #1</b>		16. SOCIAL SECURITY NO. <b>Kathryn Noonan Davis, 8714 Cameron St., SS., Md.</b>	
17. INFORMANT <b>Kathryn Noonan Davis, 8714 Cameron St., SS., Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY ATHEROSCLEROSIS</b> (c), stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>4 HRS. SEVERAL YEARS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PEPTIC ULCER</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 27, 1961</b> , to <b>JUNE 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>JUNE 17, 1961</b> , and that death occurred at <b>10:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James A. Roberts</b> 22c. PHYSICIAN'S NAME (Type) <b>JAMES A. ROBERTS M.D.</b>		22b. DATE SIGNED <b>JUNE 17, 1961</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>8907 GEORGIA AVE. SILVER SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 20, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Montgomery County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b> ADDRESS <b>Wagner E. Pumphrey, Inc., Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 22 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	





TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6920

06907

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kensington Gardens Sanitarium</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>5600 Western Avenue</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>PAUL A. DAVIS</b>		<b>4. DATE OF DEATH</b> Month <b>June 2,</b> Day <b>19 61</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 2, 1888</b>	
<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>10. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>President Electrical Fixture Firm</b>		<b>11. BIRTHPLACE</b> (County & State or foreign country) <b>Pennsylvania</b>	
<b>13. FATHER'S NAME</b> <b>James P. Davis</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mildred Hill</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Yes</b>	
<b>17. INFORMANT</b> <b>Imogene E. Davis-Wife-same 2d</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Circulatory failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>2500</b> (a), stating the underlying cause last, (c) <b>benign arterial atherosclerosis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 1/2 years</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) Who a at work <input type="checkbox"/> Not Who a at work <input type="checkbox"/>	
<b>20f. (City or town)</b> <b>5-27</b>		<b>20g. (County)</b> <b>6-2</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from 5-27, 1961, to 6-2, 1961, that (I) (we) last saw the deceased alive on 6-2, 1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>R. H. Hammond M.D.</b>		<b>22b. DATE SIGNED</b> <b>June 2/61</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>KEMP H. MISH</b>		<b>22d. ADDRESS</b> <b>2011 - R Street, N.W., Washington, D. C.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>6/5/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rock Creek Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> <b>Washington, D. C.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b>		<b>25a. REC'D BY REGISTRAR</b> <b>Bethesda, Maryland</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE JUN 8 '61</b>		<b>25c. REGISTRAR'S SIGNATURE</b> <b>Lincoln S. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

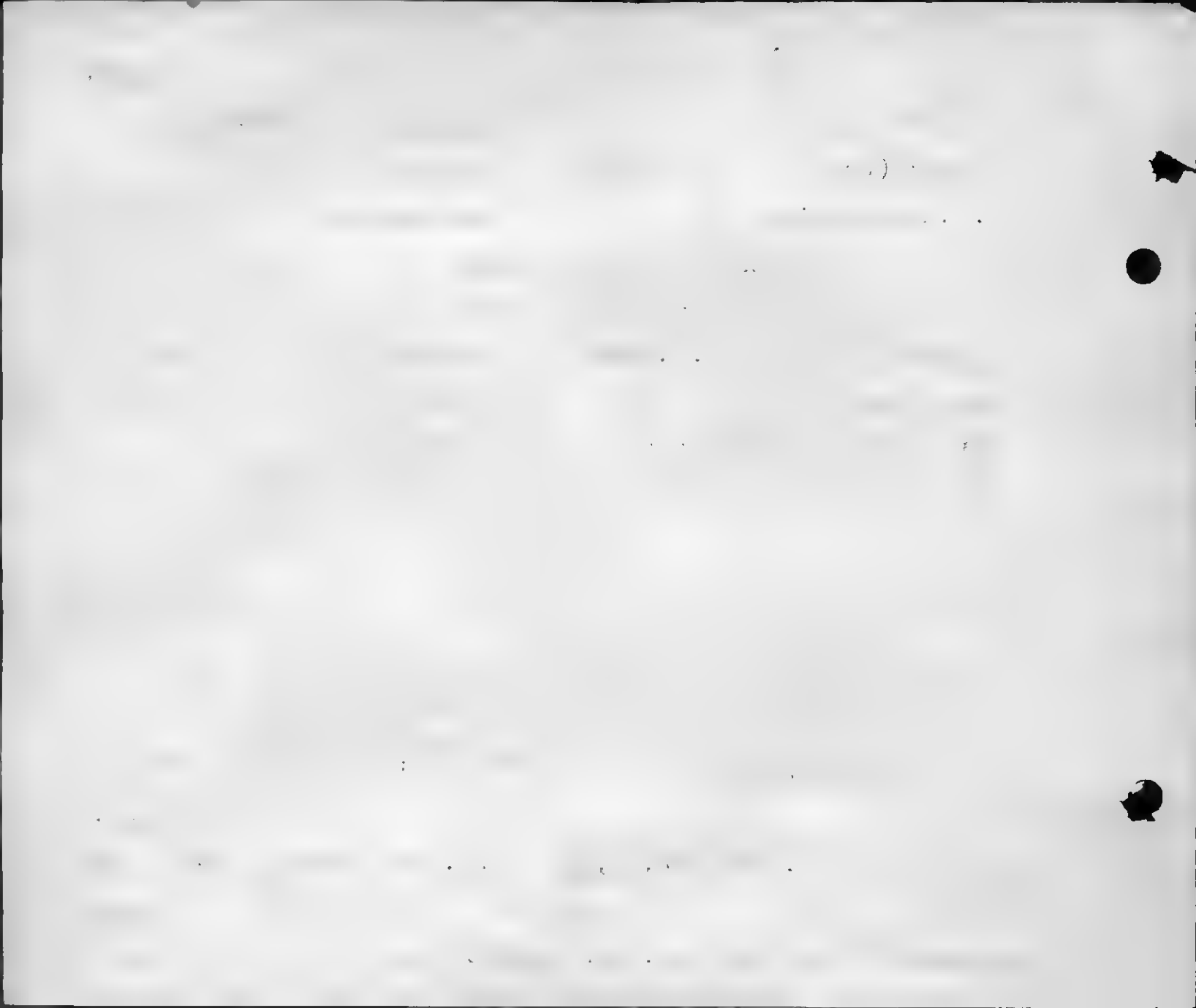
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6921

06909

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>267 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>Chevy Chase Club</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Oliver Lee DOWNES</b>		<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>21</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Caucasian</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8-29-89</b>
<b>9. AGE</b> (In years last birthday) <b>71 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Officer U. S. Navy</b>	
<b>11. BIRTHPLACE</b> County & State, or foreign country <b>Delaware</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Samuel DOWNES</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary PERRY</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>9/6/08 to 1/4/7</b>		<b>16. SOCIAL SECURITY NO</b> <b>264-54-5908</b>	
<b>17. INFORMANT</b> <b>Hospital Records</b>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon (cecum)</b> DUE TO <b>175.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>175.0</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> <b>40</b> (this hospital) attended the deceased from <b>Sept. 27, 1960</b> to <b>June 21, 1961</b> , that <b>45</b> (we) last saw the deceased alive on <b>June 21, 1961</b> , and that death occurred at <b>2:30PM</b> M, from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Larry J. Hines</b> <b>Larry J. HINES, CDR, MC, USN</b>		<b>22b. DATE SIGNED</b> <b>6-21-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Larry J. HINES, CDR, MC, USN</b>		<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>6-23-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington Virginia</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Jos. Gawlers &amp; Sons</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUN 26 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6822

## CERTIFICATE OF DEATH

Reg. Dist. No.

CC910

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie Lucille Drummond</u>				4. DATE OF DEATH Month Day Year <u>June 20 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 13, 1886</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gilbert</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Grossman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Washington Sanitarium and Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe coronary insufficiency</u> DUE TO (c) <u>Severe arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH minutes <u>minutes</u> years <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/18/61</u> , 19 <u>60</u> , to <u>6/20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/19/61</u> , 19 <u>61</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. T. Morse</u>				ADDRESS (Street, city or town, state) <u>5030 Carroll Ave</u>			
PHYSICIAN'S NAME (Type) <u>H. T. Morse</u>				DATE SIGNED <u>6/20/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 23-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frederick Law</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Waters</u>				ADDRESS <u>254 Carroll St. N.W.-D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 23 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

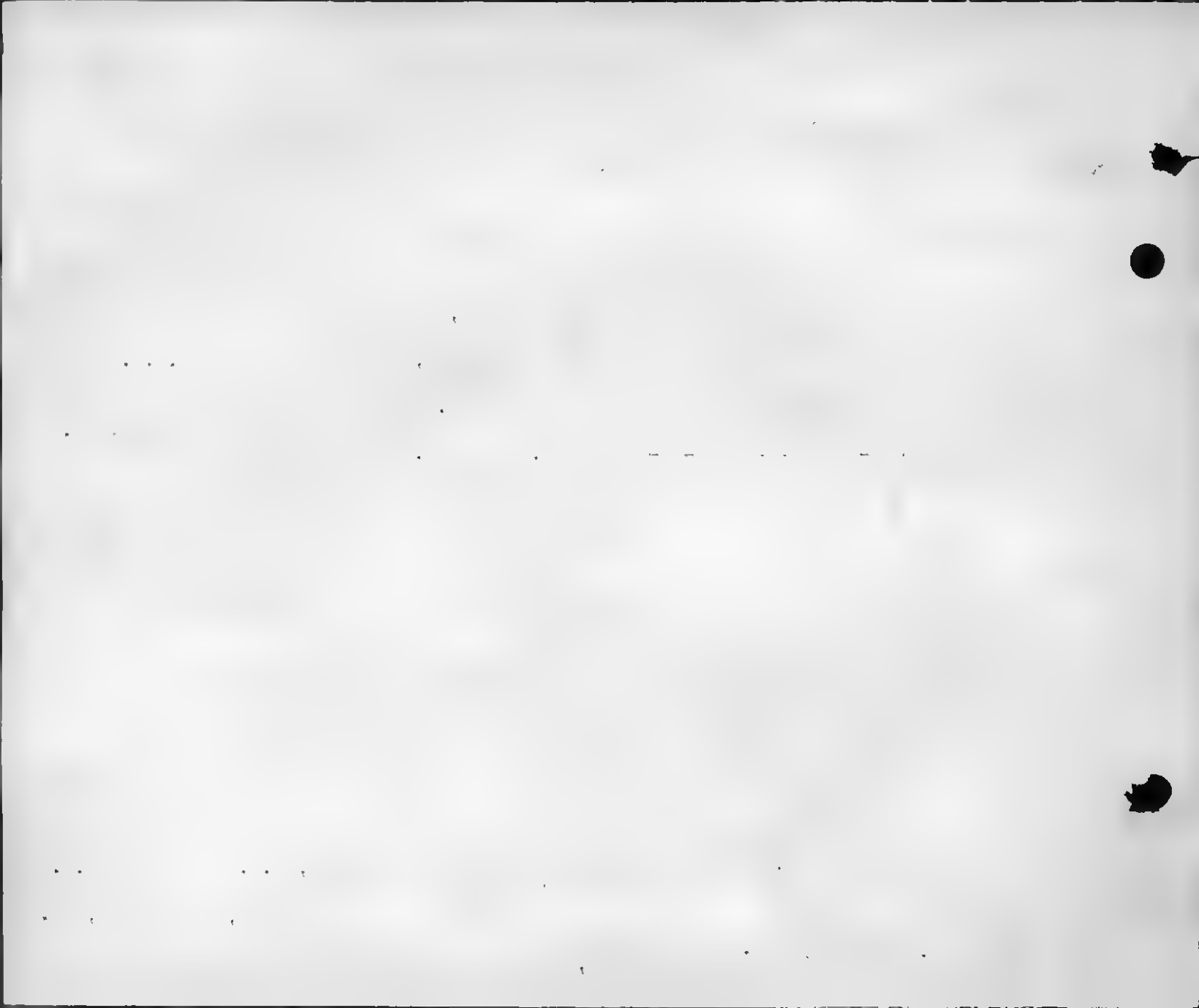
## CERTIFICATE OF DEATH

6923

06911

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>31 years</u>		d. STREET ADDRESS <u>2023 Lanier Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2023 Lanier Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Cora</u> First <u>M.</u> Middle <u>G.</u> Last <u>Guthrie</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1900</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Israel Deacon Vocum</u>		14. MOTHER'S MAIDEN NAME <u>Abbie G. Huffman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-42-1746</u>	
17. INFORMANT <u>Mrs. Arthur L. Hanson</u>		Address <u>2023 Lanier Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Carcinoma of intestinal (small) tract.</u> 15-2-7 DUE TO Conditions, if a which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>7/5/1960</u> to <u>6/21/1961</u> , that (I) (we) last saw the deceased alive on <u>June 21, 1961</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>A. B. Little</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE MD</u> 22b. DATE SIGNED <u>June 21, 1961</u> 22d. ADDRESS <u>6911 Fifth Street, N.W. Washington D.C.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6/23/61</u> 23c. NAME OF CEMETERY*OR CREMATORY <u>Forest Oak Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Gaithersburg, Montgomery, Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u> 25a. REC'D BY REGISTRAR <u>June 27 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

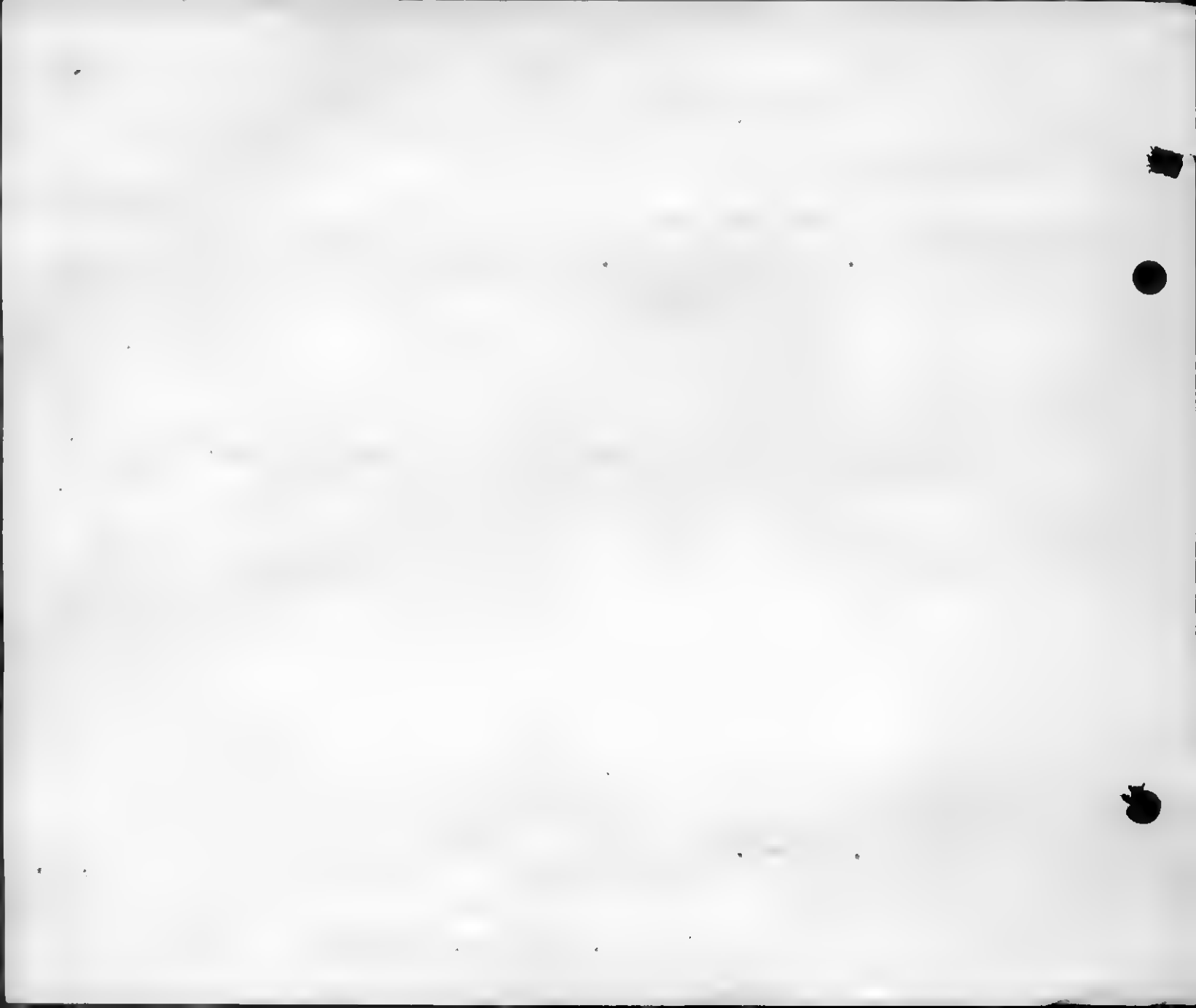
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6924

08158

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>3404 W. Coquelin Terrace</b> <b>Ch. Ch. Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) STATE <b>Md.</b> COUNTY <b>Montg.</b> <b>3404-W. Coquelin Ter. Ch. Ch. Md. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase Md.</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>51</b>	
3. NAME OF DECEASED (Type or print) First <b>Mrs.</b> Middle <b>Mary</b> Last <b>H. Durbin</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15 1883</b>
9. AGE (In years last birthday) <b>78 1/2 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Bolling Green, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Fleming,</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Howard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Margaret P. Durbin-</b>		Address <b>3404-W. Coquelin Ter. Ch. Ch. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Congestive heart failure</b> DUE TO (b) <b>Coronary artery disease</b> DUE TO (c) <b>10 years</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General vascular disease, Diabetes, high lipids, Pulmonary embolism</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 29</b> 19 <b>54</b> , to <b>Jan 28</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Jan 26</b> 19 <b>61</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Blaine H. Eig</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Blaine H. Eig</b>		22d. ADDRESS <b>8641 Colesville Road, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-3-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bowling Green</b>		23d. LOCATION (City, town, or county) (State) <b>Kentucky</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas B. Houlton</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 18 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert S. Thomas</b>			



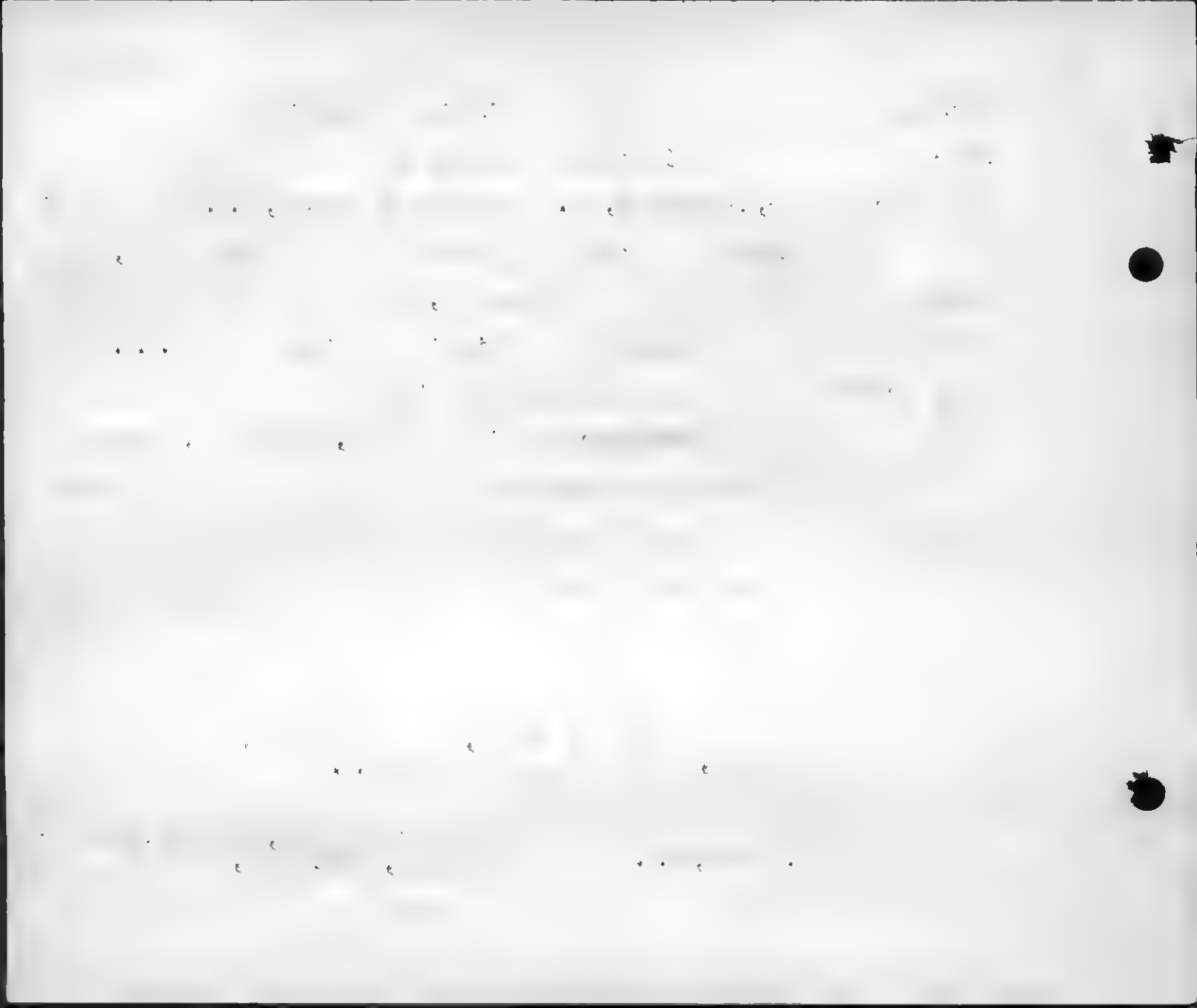
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MAY 23 1961  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06912

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <b>District of Columbia</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>30 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>Mary</b> Last <b>Dyson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1908</b>
9. AGE (In years last birthday) yrs <b>53</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Duckett</b>		14. MOTHER'S MAIDEN NAME <b>Janie Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>538-053565</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>Unavailable The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Metastases from</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Carcinoma of Cervix with</b> DUE TO (c) <b>Metastases to lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>1 year</b> <b>3 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 23, 1961</b> to <b>June 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 22, 1961</b> , and that death occurred at <b>6:00 a.m.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Donald L. Morton</b> M.D.	
22b. PHYSICIAN'S NAME (Type) <b>DONALD L. MORTON, M.D.</b>		22c. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/26/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEM. CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>SUITLAND, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Alfred J. Pope</b>		25a. REC'D BY REGISTRAR <b>414-15<sup>th</sup> ST S.E.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles P. Kimes</b>		DATE <b>JUN 23 '61</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G289 6/26/61 jrk

## CERTIFICATE OF DEATH

Reg. Dist. No.

06913

0926

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING Hyattsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FARLAND NURSING HOME</b>				d. STREET ADDRESS <b>5504 43rd. Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>E.</b> Last <b>EBERHART</b>				4. DATE OF DEATH Month <b>6</b> - Day <b>18</b> - Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-28-66</b>	
9. AGE (In years last birthday) <b>95</b> yrs.		IF UNDER 1 YEAR Months <b>95</b> Days <b>95</b> Hours <b>95</b> Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB PARKER</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO (If yes, give war or state of service) <b>NONE</b>		17. INFORMANT <b>WILLIAM F. EBERHART</b> Address <b>5504 43RD PLACE HYATTSTVILLE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b> <b>450.0</b> DUE TO							<b>known 4 years.</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO							<b>unable to state</b>
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 4, 1957</b> to <b>June 18, 1961</b> , that I last saw the deceased alive on <b>June 11, 1961</b> , and that death occurred at <b>MD</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Caron H. Traum</b>				ADDRESS (Street, city or town, state) <b>8237 Georgia Ave Silver Spring MD</b> DATE SIGNED <b>6/19/61</b>			
PHYSICIAN'S NAME (Type) <b>HARRON H. TRAUM</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-21-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CITY CEM</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Riverdale Md.</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>JUN 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. H. of H. and</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. If the deceased was in a hospital or attending physician, the certificate should be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6927

06914

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
c. LENGTH OF STAY IN 1b <b>1 Year</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>105 James St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>MYRTLE</b> Last <b>EYLER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1961</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 13 1890</b>
9 AGE (In years last birthday) <b>71</b> yrs		IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pract. Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Harrison</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia Warthen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO. <b>578 36 8319</b>	
17. INFORMANT <b>Leslie E. Mullineaux</b>		Address <b>Same As 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO (b) <b>Inoperable Cancer of breasts</b> DUE TO (c) <b>Possible generalized Metastasis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 19 61</b> to <b>6/19 1961</b> , that (I) (we) last saw the deceased alive on <b>6/10 1961</b> , and that death occurred at <b>6/19 1961</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lucius R. Leal</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>L. I. Leal</b>		22d. ADDRESS <b>Gaithersburg, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 22 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hyattstown</b>	23d. LOCATION (City, town, or county) (State) <b>Hyattstown Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, MD.</b>	
25a. REC'D BY REGISTRAR DATE <b>JUN 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Lucius R. Leal</b>	

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6-22-12 General Hospital

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06915

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Xolney</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>J</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <b>DECEASED</b> (Type or print) First Middle Last <b>Samuel Josiah Finneyfrock</b>				4. DATE OF DEATH Month Day Year <b>6 11 1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/28/1885</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Blacksmith</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Finneyfrock</b>				14. MOTHER'S MAIDEN NAME <b>Anna Schutly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-34-1061</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Cerebral Arterio Sclerosis</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>11 hrs.</b> years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/11 1961</b> to <b>6/11 1961</b> , that (I) (we) last saw the deceased alive on <b>6/11 1961</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Richard A. Yates M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Yates</b>				22d. ADDRESS <b>Olney, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-14-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Olney, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 19 1961</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

6629

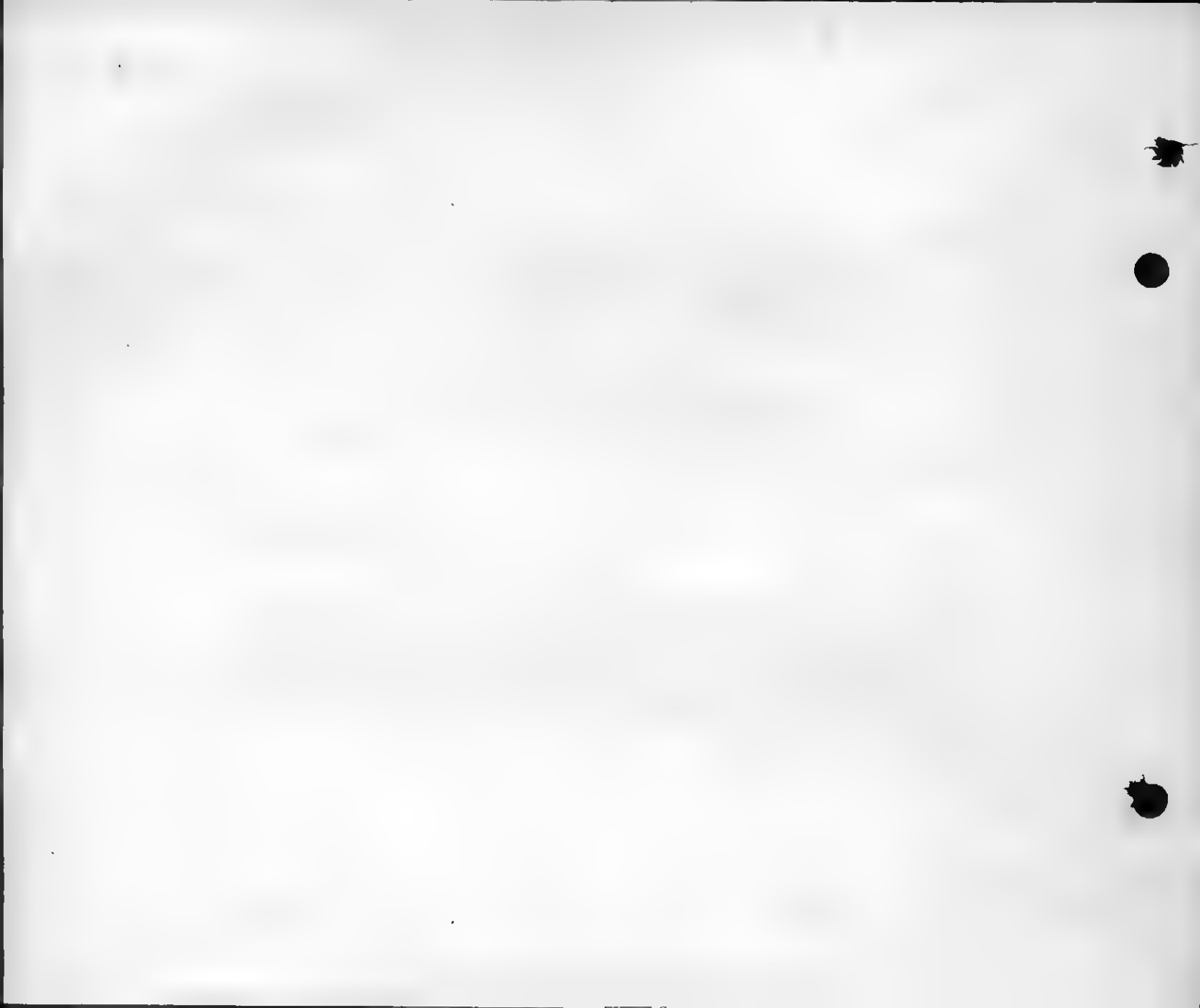
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06916

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FARMLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ADDELPHI</b>			
c. LENGTH OF STAY IN 1b <b>4/9/61-6/8/61</b>				d. STREET ADDRESS <b>2526 Buck Lodge Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FARMLAND NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jessie</b> Middle <b>MARIE</b> Last <b>FITZWATER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 3 - 1896</b>	
9. AGE (in years last birthday) <b>65</b> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph MANUEL</b>				14. MOTHER'S MAIDEN NAME <b>Eva Meeks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>3</b>		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Parkinson's Disease</b> <b>250X</b> DUE TO (b) <b>Cerebral arterio sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Cardiac Failure</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs.</b> <b>18 yrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>4/9/61</b> to <b>6/8/61</b> , that (I) (we) last saw the deceased alive on <b>6/8/61</b> , and that death occurred at <b>10</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>J. E. Virnstein</b> M.D.				22b. DATE SIGNED <b>6/8/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. E. VIRNSTEIN</b>				22d. ADDRESS <b>3311-16-77th Ave. N.W.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>burial</b>		<b>6/10/61</b>		<b>Valley View Cemetery</b>		<b>Nokesville, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Hines Co</b> ADDRESS <b>2901 14th NW</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>	

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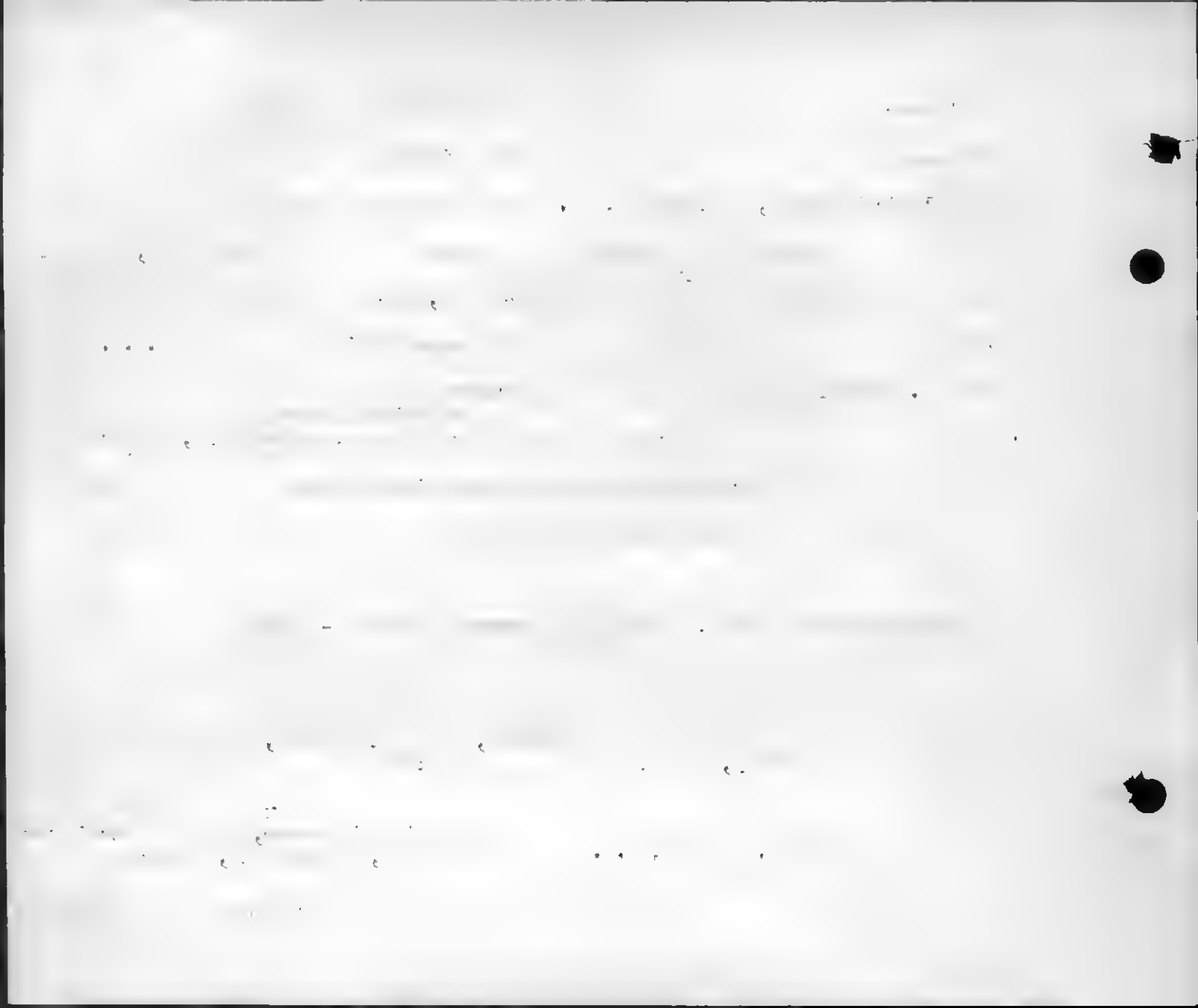
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06917

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>West Pittston</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>906 Susquehanna Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jehn</b> Middle <b>Harold</b> Last <b>Flannery</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3,</b> Year <b>19 61</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1898</b>
9. AGE (In years last birthday) yrs <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Judge</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Flannery</b>		14. MOTHER'S MAIDEN NAME <b>Bridget Tighe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute &amp; chronic respiratory insufficiency</b> 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Bronchiectasis &amp; emphysema</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Atherosclerosis of aorta, coronaries &amp; cerebral vessels - severe</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 2, 1961</b> to <b>June 3, 1961</b> that (I) (we) last saw the deceased alive on <b>June 3, 1961</b> and that death occurred at <b>4:30PM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>C. W. McBride</b>		22b. DATE SIGNED <b>6/4/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Orlando W. McBride, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/6/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		23d. LOCATION (City, town, or county) (State) <b>Pittston, Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert C. Thompson</b>		25a. REC'D BY REGISTRAR <b>JUN 8 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6931

Item 9 Film 3289 b/c/b/w iwk

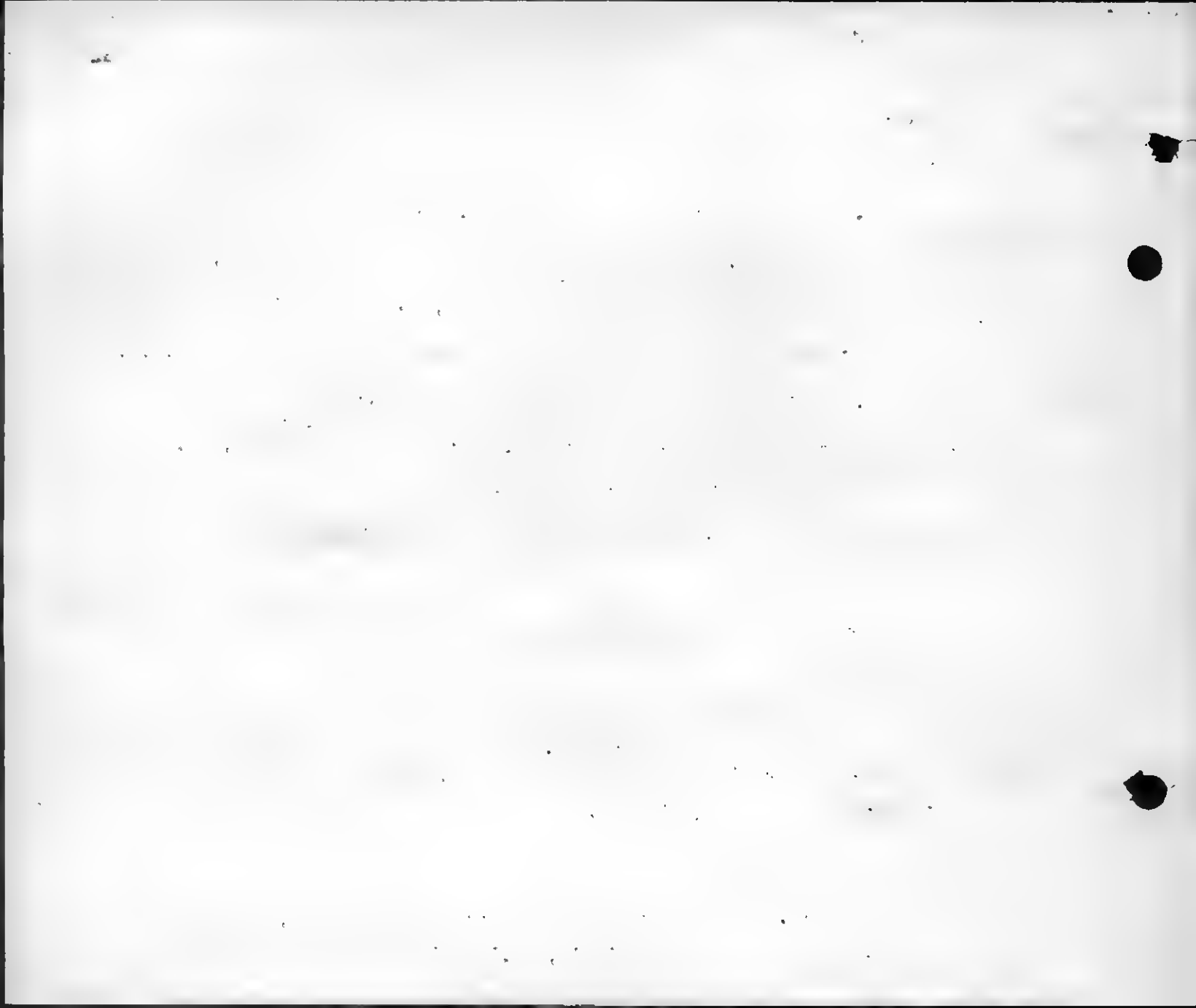
CERTIFICATE OF DEATH

Reg. Dist. No.

06918

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 E. Argyle Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>M.</u> Last <u>Foley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1887</u>	
9. AGE (In years last birthday) <u>74</u> <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse (retired)</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert J. Foley</u>				14. MOTHER'S MAIDEN NAME <u>Julia Meagher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War I</u>				16. SOCIAL SECURITY NO. <u>--</u>			
17. INFORMANT <u>Ann M. Foley</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 2865 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition, mental depression</u> DUE TO (c) <u>1 year.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Radiation therapy for carcinoma of breast 1949.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1955</u> 19 to <u>June 21, 1961</u> , that I last saw the deceased alive on <u>June 17, 1961</u> , and that death occurred at <u>110 S. Washington St.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. A. Lenthicum</u> M.D.				ADDRESS (Street, city or town—state) DATE SIGNED <u>110 S. Washington St. 6/21/61</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM A. LINTHICUM, M.D.</u>				<u>Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE OF BURIAL, CREMATION, OR REMOVAL <u>6/23/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Maria Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 23 '61</u>			
ADDRESS <u>1331 E. Montg. Ave. Rockville, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

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TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

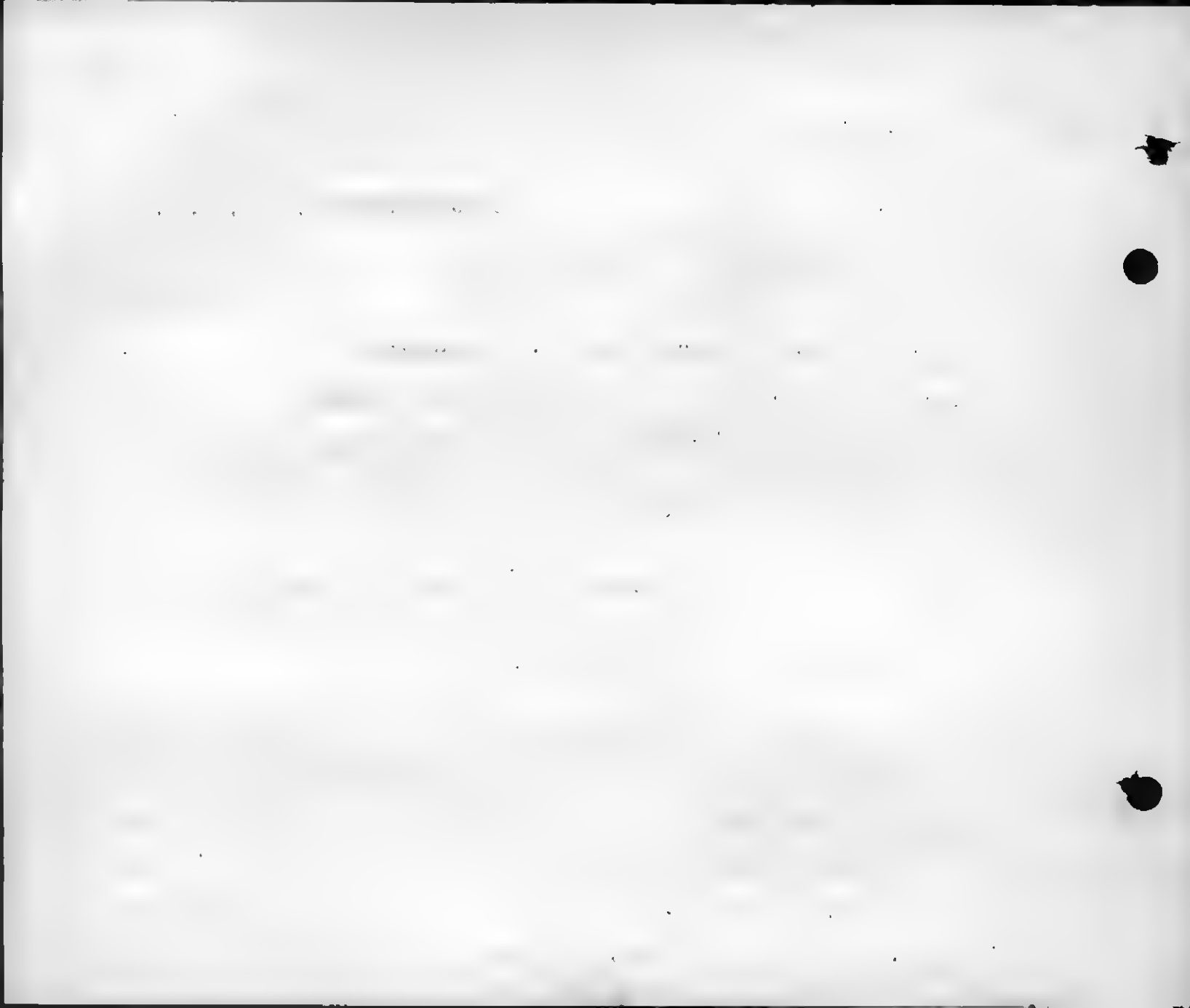
1. The law requires that the death certificate be executed within 72 hours after death.

6932

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06919

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> D C b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 1/2</u> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4200 Cathedral Avenue, N. W.</u>			
3 NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>(nmi)</u> Last <u>FORD</u>				4 DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/2/90</u>	
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bogley Reas Est.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Henry Jones Ford</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Batory</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Wife Kathryn Ford (same as above)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> (c) <u>Old inactive rheumatic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No accident</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>No accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>May 12, 1961</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Prince Georges Maryland</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>May 12, 1961</u> to <u>June 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 5, 1961</u> and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>George Buchanan</u>				22b. ADDRESS <u>1834 Eye St. N.W. Wash. D.C.</u>			
22c. PHYSICIAN'S NAME (Type) <u>George Buchanan</u>				22d. ADDRESS <u>1834 Eye St. N.W. Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>6/6/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>JUN 8 1961</u>			
ADDRESS <u>Bethesda, Maryland</u>				25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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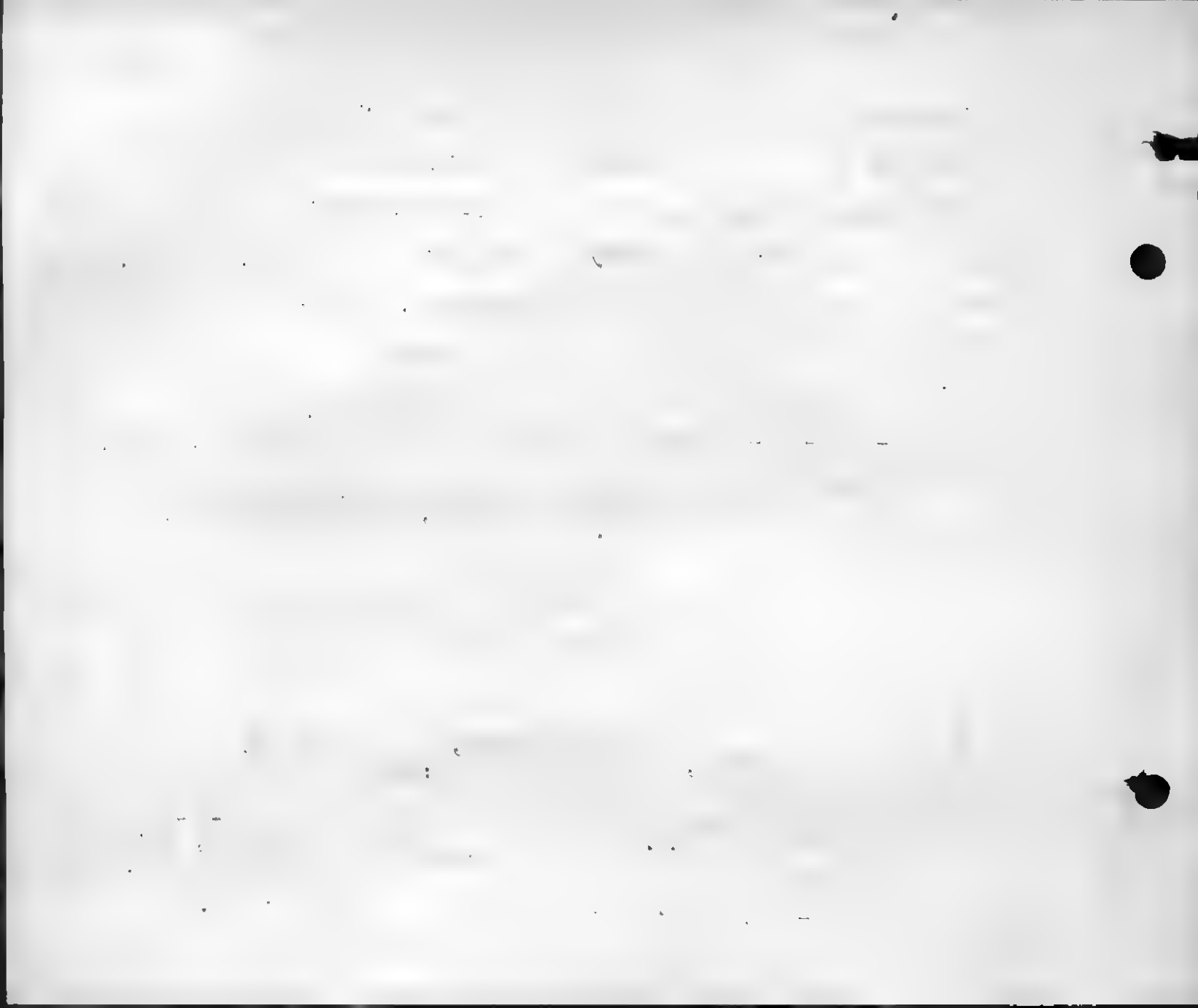
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06920

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>29 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Uniontown</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Uniontown</b> d. STREET ADDRESS <b>31 Evans Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>(K)</b> Last <b>Galderisi</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 15, 1905</b> 9. AGE (In years lost birthday) <b>55</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Koballa</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hardy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiogenic Carcinoma of Right main Bronchus</b> DUE TO (b) <b>with metastasis to Adrenals, lymph Nodes, Thyroid, and pancreas.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 14, 19 61</b> to <b>June 12, 19 61</b> that (I) (we) last saw the deceased alive on <b>June 12, 19 61</b> , and that death occurred <b>2:15 PM</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Leo Stolbach</b>	22b. DATE SIGNED <b>6-12-61</b>
22c. PHYSICIAN'S NAME (Type) <b>Leo Stolbach M.D.</b>	22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>

23a. BURIAL, CREMATON REMOVA. (Specify) <b>Removal</b>	23b. DATE THEREOF <b>6-13-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hopwood, Pa.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Guerin, Inc. 1756 6a. Ave. P.O.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 14 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Robert S. Adams</b>



may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>41 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>PAULINE</b> Last <b>GENIES</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 14, 1914</b>
9. AGE (In years last birthday) <b>46</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Reuben Dove</b>		14. MOTHER'S MAIDEN NAME <b>Flora Hogan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c). <b>Pseudomonas septicemia</b> <b>Adenocarcinoma of the uterus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>3 wks</b> <b>several months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> p. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 3, 1961</b> to <b>June 13, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 13, 1961</b> and that death occurred at <b>11:35AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>David T. Crawford M.D.</b>		22b. DATE SIGNED <b>6/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>David T. Crawford, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/17/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park.,</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sworde</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 20 '61</b>	
ADDRESS <b>Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



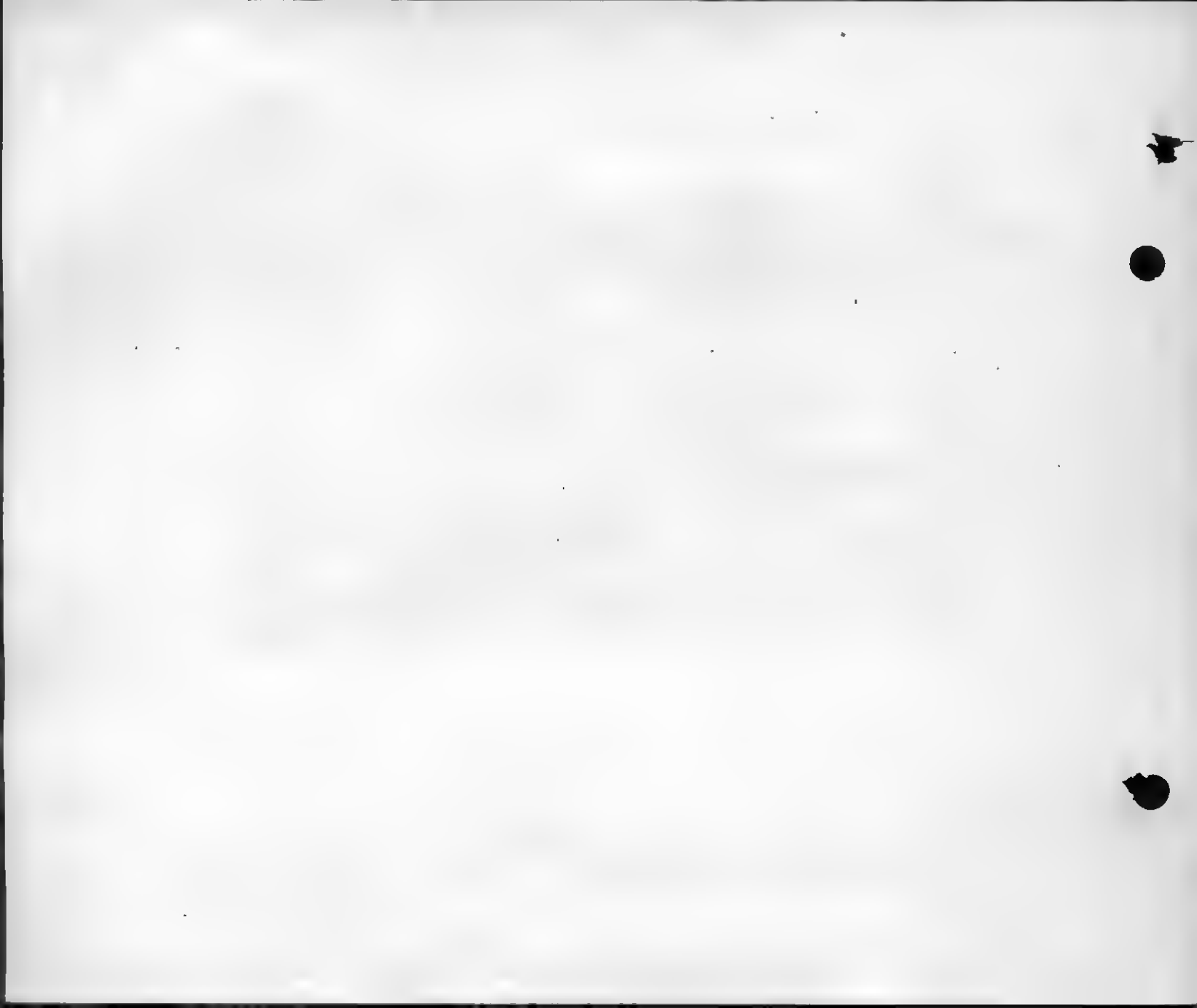
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06922

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 21	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>903 Malcolm Drive</b>		d. STREET ADDRESS <b>903 Malcolm Drive</b>	
3. NAME OF DECEASED (Type or print) <b>GEOGHEGAN, EARL</b>		4. DATE OF DEATH Month <b>6</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-1880</b>
9 AGE (In years last birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.N. Air Stat</b>	
11 BIRTHPLACE (State or foreign country) <b>Shelby County, Ky</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. <del>Married</del> Fathers name <b>John Geoghegan</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Caplinger</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>400 28 2119</b>	
17 INFORMANT <b>Claude Geoghegan</b>		Address <b>Same as # 2</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Senility</b> <b>450.0</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b> 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1961</b> to <b>June 19, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 3, 1961</b> , and that death occurred at <b>7:00</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernard A. Fitzgerald</b>		22b. DATE SIGNED <b>6-17-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bernard A. Fitzgerald</b>		22d. ADDRESS <b>217 UNIVERSITY BLVD E S.E. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-20-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town, or county) (State) <b>Silver Spring, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Mattingly</b>		25a. REC'D BY REGISTRAR <b>Wash. DC</b>	
25b. REGISTRAR'S SIGNATURE <b>June 21 '61</b>		25c. DATE <b>June 21 '61</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORONER HAS BEEN NOTIFIED AND APPROVES.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained at the hospital, or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

6536

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06923

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>57 1/2 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>Box 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>DIONISUS</b> Last <b>GLOYD</b>				4. DATE OF DEATH Month <b>6</b> Day <b>1</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/12/88</b>	9. AGE (In years last birthday) <b>72 yrs</b>	IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>insurance agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob A. Gloyd</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Clents</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>hospital records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>B ILATERAL BRONCHOPNEUMONIA</b> DOE TO <b>MYOCARDIAL INFARCTION (OLD)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> DUE TO (c) <b>?</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACUTE OR CHRONIC WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify (I) (this hospital) attended the deceased from <b>2/3/61</b> , 19 <b>61</b> , to <b>6/1</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6/1</b> , 19 <b>61</b> , and that death occurred at <b>7:20 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. D. Bonifant</b>				22b. DATE SIGNED <b>6/1/61</b>		22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b>	
22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>				22e. ADDRESS <b>SANDY SPRING, MARYLAND</b>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>6-5-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Rose</b>		23d. LOCATION (City, town, or county) (State) <b>Gaithersburg R 46 Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thoms</b>				25a. REC'D BY REGISTRAR <b>ARTHUR S. THOMS</b>		25b. REGISTRAR'S SIGNATURE <b>ARTHUR S. THOMS</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6937

06924

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Park</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hash San &amp; Hosp</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1125 Spring Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joseph (NMM) Gottlieb</u>		<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>5</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3-7-76</u>	
<b>9. AGE</b> (In years last birthday) <u>85</u> yrs.                 IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired School teacher</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Lithuania</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u>		<b>13. FATHER'S NAME</b> <u>Abraham Gottlieb</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Judith Vashevsky</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>none</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>p't Hosp. record.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured colon diverticulum</u> 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>June 5, 1961</u> Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct 1957</u> <b>to</b> <u>June 5, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>June 5, 1961</u> , <b>and that death occurred at</b> <u>12:30 PM</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Abraham W. Danis</u>		<b>22b. DATE SIGNED</b> <u>6/5/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ABRAHAM W. DANIS</u>		<b>22d. ADDRESS</b> <u>927 Washington B Silver Spring Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>JUNE 7, 1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>WASHINGTON CEMETERY</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>BROOKLYN N.Y.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>B. Danzansky</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE JUN 7 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Frank</u>		<b>25c. ADDRESS</b> <u>3501-14 St. N.W.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

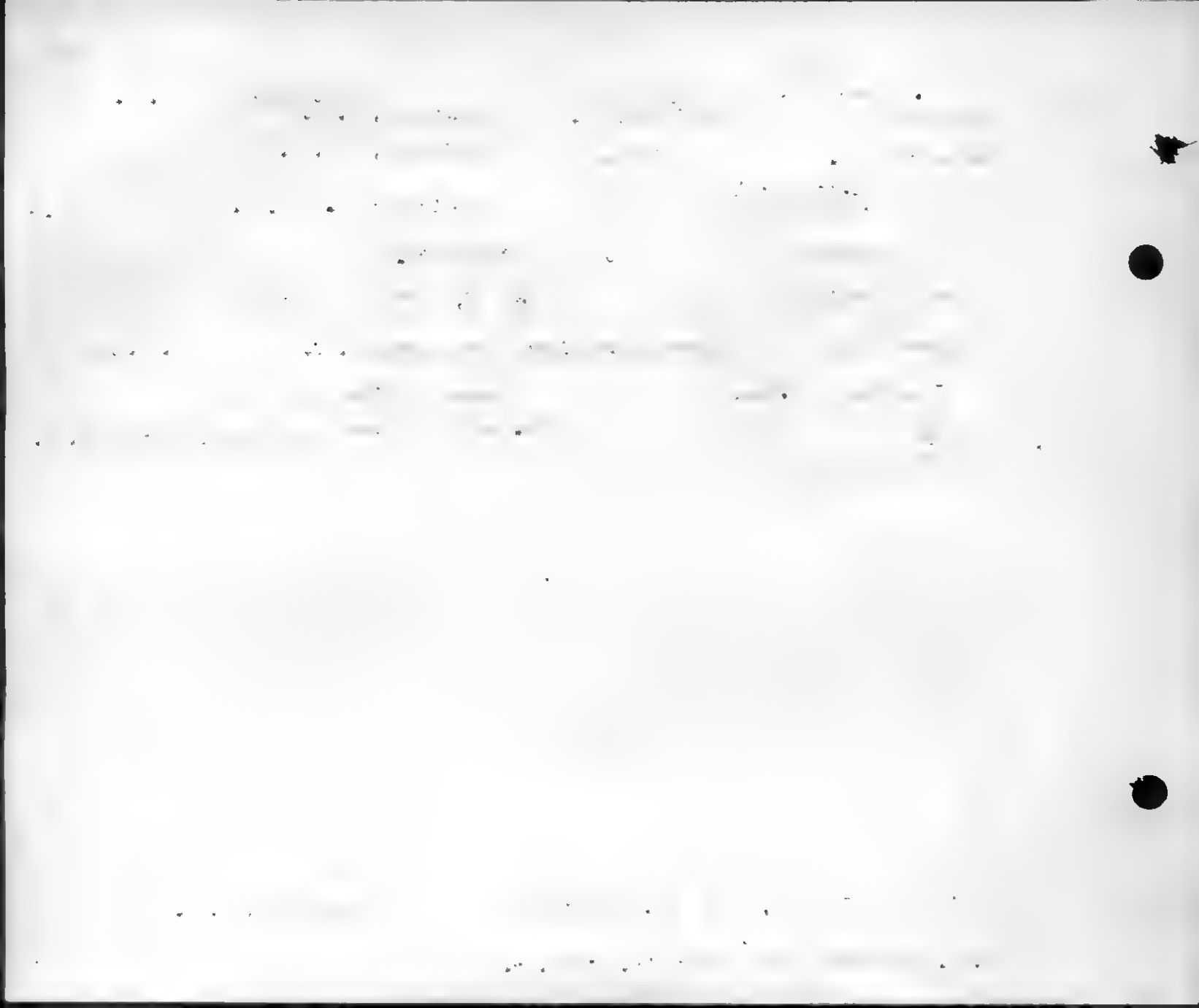
Item 9 Film 3288 6/16/61 mh

## CERTIFICATE OF DEATH

Reg. Dist. No. **06925**

<b>1 PLACE OF DEATH</b> COUNTY <b>Carroll Hall Rest Home</b> <b>Montgomery Kensington Md.</b>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>5620 Colorado Ave N. W.</b> <b>Washington, D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington Md.</b>		c. LENGTH OF STAY IN lb <b>Six Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10231 Carroll Hall Rest Home</b> <b>Carroll Place</b>		d. STREET ADDRESS <b>5620 Colorado Ave N. W.</b>	
<b>3 NAME OF DECEASED</b> (Type or print) <b>Edward</b>		<b>4 DATE OF DEATH</b> Month <b>JUNE</b> Day <b>10</b> Year <b>1961</b>	
<b>5 SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8 DATE OF BIRTH</b> <b>Dec 8, 1876</b>
<b>9 AGE</b> (In years last birthday) <b>84 1/2</b> yrs		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Electrician</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Washington D. C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A</b>	
<b>13. FATHER'S NAME</b> <b>Jonathan Gram</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Agnes Wisd</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO</b> <b>INFORMANT</b> Address <b>Mrs. Marie M Milans 816 Randolph Street N. W.</b>	
<b>18 CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> + 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <b>MARCH 13, 1956</b> , to <b>JUNE 10, 1961</b> , that I last saw the deceased alive on <b>JUNE 10</b> , 19 <b>61</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <i>Kenyan London</i> M.D.		<b>ADDRESS</b> (Street, city or town, state) <b>5206 NORWAY DR.</b> <b>DATE SIGNED</b> <b>6/10/61</b>	
<b>PHYSICIAN'S NAME (Type)</b> <b>CHEVY CHAST, MD</b>		<b>22a. BURIAL, CREMATION, or other disposal</b> (Specify) <b>Burial</b>	
<b>22b. DATE THEREOF</b> <b>June 13, 1961</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet Cem</b>	
<b>22d. LOCATION</b> (City, town, or county) (State) <b>Washington, D. C.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 14 '61</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>W. K. Huntemann &amp; Son</i> ADDRESS <b>5732 Co. Ave N. W.</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Charles S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6939

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66926

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN TB <b>DOA</b>			
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>				d. STREET ADDRESS <b>2211 L. St. N.W.</b>			
3. NAME OF DECEASED (Type or print) <b>Anna E. Green</b>				4. DATE OF DEATH <b>June 12 19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-23-06</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. <b>55 yrs.</b>		11. BIRTHPLACE (State or foreign country) <b>DO</b>	
13. FATHER'S NAME <b>?</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				17. INFORMANT <b>Elsie Moore</b> Address <b>Wash. D.C. 1459 Hobart St. N.W.</b>			
16. SOCIAL SECURITY NO. <b>578-44-0977</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>hypertension</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>History of previous heart disease</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Brochart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>6/17/61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>HARMONY</b>				22d. LOCATION (City, town, or country) (State) <b>MD</b>			
23. FUNERAL DIRECTOR <b>MARION H. BOYD</b>				24a. REC'D BY REGISTRAR <b>JUN 16 '61</b>			
ADDRESS <b>719 Kennedy</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH  
**sudden**  
**years**

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

DATE SIGNED  
**6-12-61**





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

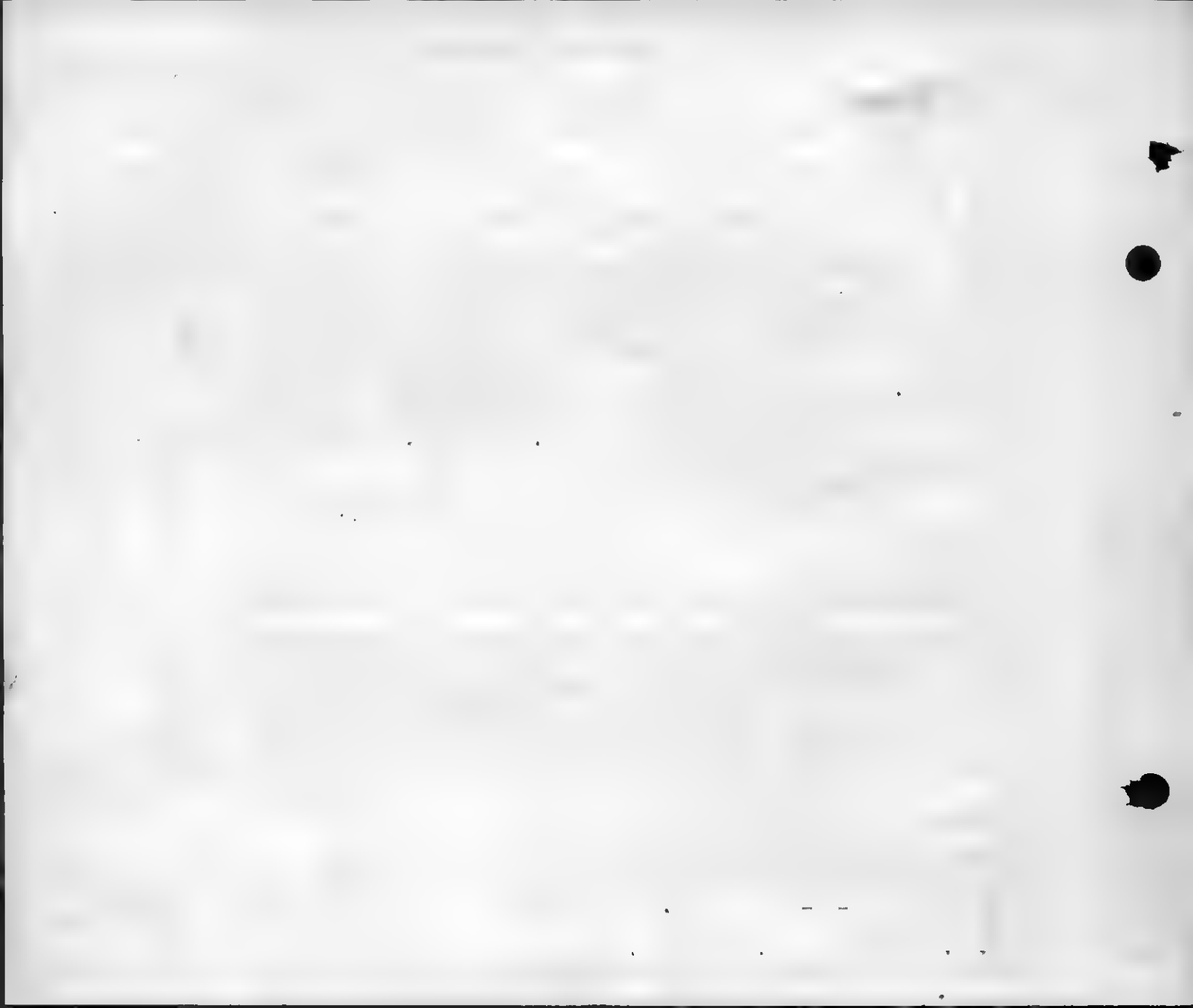
6540

## CERTIFICATE OF DEATH

Reg. Dist. No. 06927

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Point of Rocks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>1532 Red Oak Drive</b>		d. STREET ADDRESS <b>10X-2</b>	
3. NAME OF DECEASED (Type or print) First <b>ALTA</b> Middle <b>LEONA</b> Last <b>HARNE</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 March 1878</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>14</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph L. Redmond</b>		14. MOTHER'S MAIDEN NAME <b>Olivia Pryor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Lillian C. Landis (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of recto sigmoid</b> <b>154X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Terminal Myelonephritis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>5</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 30, 1960</b> to <b>June 14, 1961</b> , that I last saw the deceased alive on <b>June 14, 1961</b> , and that death occurred at <b>11:19 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sydney Leventhal</b> M.D.		ADDRESS (Street, city or town, state) <b>9210 Coleville Rd., Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Sydney Leventhal</b>		DATE SIGNED <b>June 17, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-17-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Bethel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick County Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 16 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fiano</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6841

## CERTIFICATE OF DEATH

Reg. Dist. No.

C6928

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7109 Radnor Rd.</b>		d. STREET ADDRESS <b>7109 Radnor Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>L.</b> Last <b>HEIDER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 8, 1912</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Leba</b>		14. MOTHER'S MAIDEN NAME <b>Anna Lechvoich</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-18-6120</b>	
17. INFORMANT <b>Mr. William F. Heider, 7109 Radnor Rd. Bethesda, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma Colon c Metastasis</b> DUE TO <b>to Liver, etc.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 11, 1960</b> , to <b>June 16, 1961</b> , that I last saw the deceased alive on <b>June 16, 1961</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul Eanet</b>		ADDRESS (Street, city or town, state) <b>6727-16th St. N.W.</b>	
PHYSICIAN'S NAME (Type) <b>PAUL EANET M.D.</b>		DATE SIGNED <b>6-16-61</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/19/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven C. M.</b>		22d. LOCATION (City, town, or county) (State) <b>Georgia Ave. S.W. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Funeral Home</b>		ADDRESS <b>5193 Wisconsin Ave. N.W. Wash. D.C.</b>	
24a. REC'D BY REGISTRAR <b>JUN 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

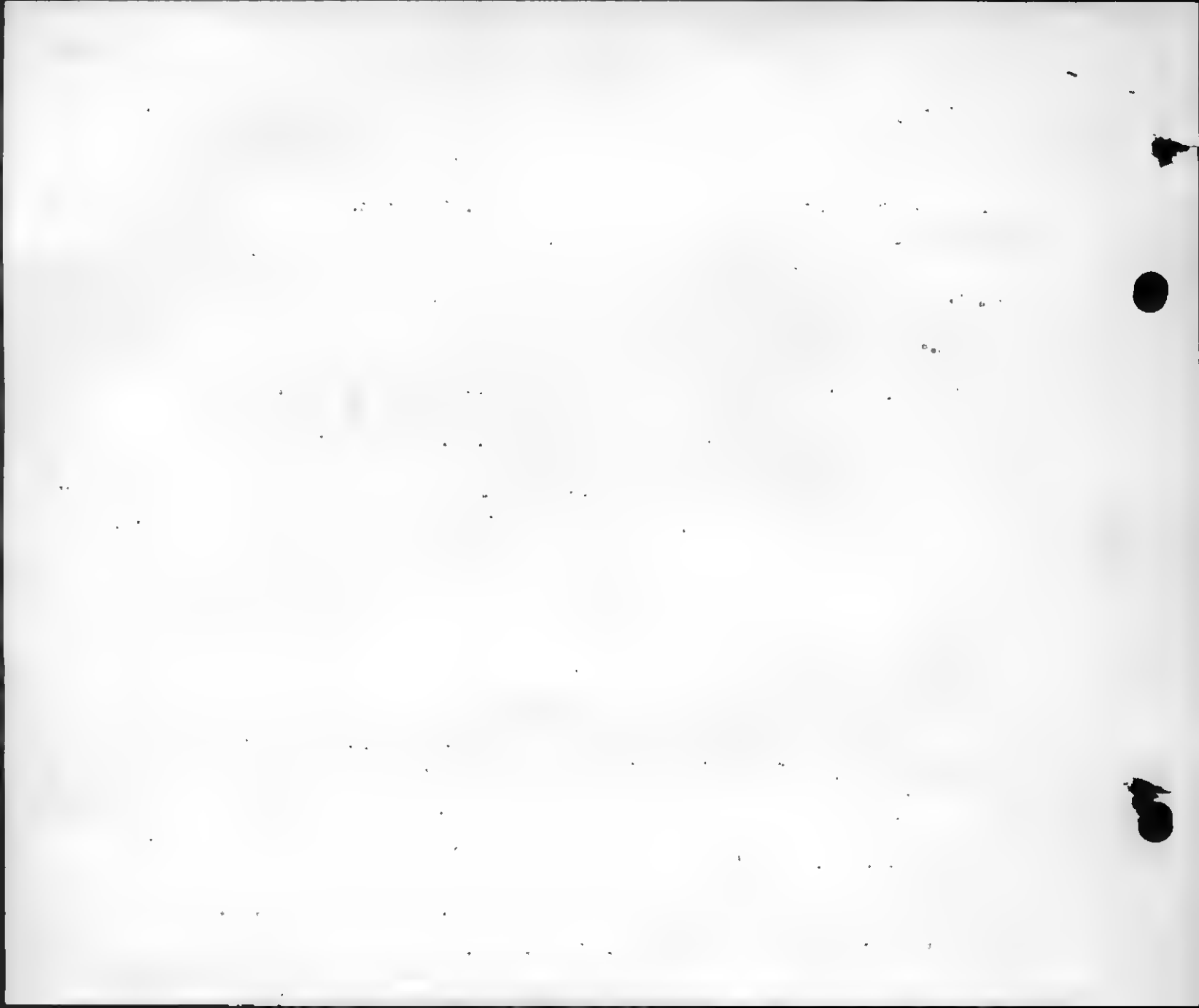
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VE AIS (4)  
ISM 9/SB

MEDICAL CERTIFICATION

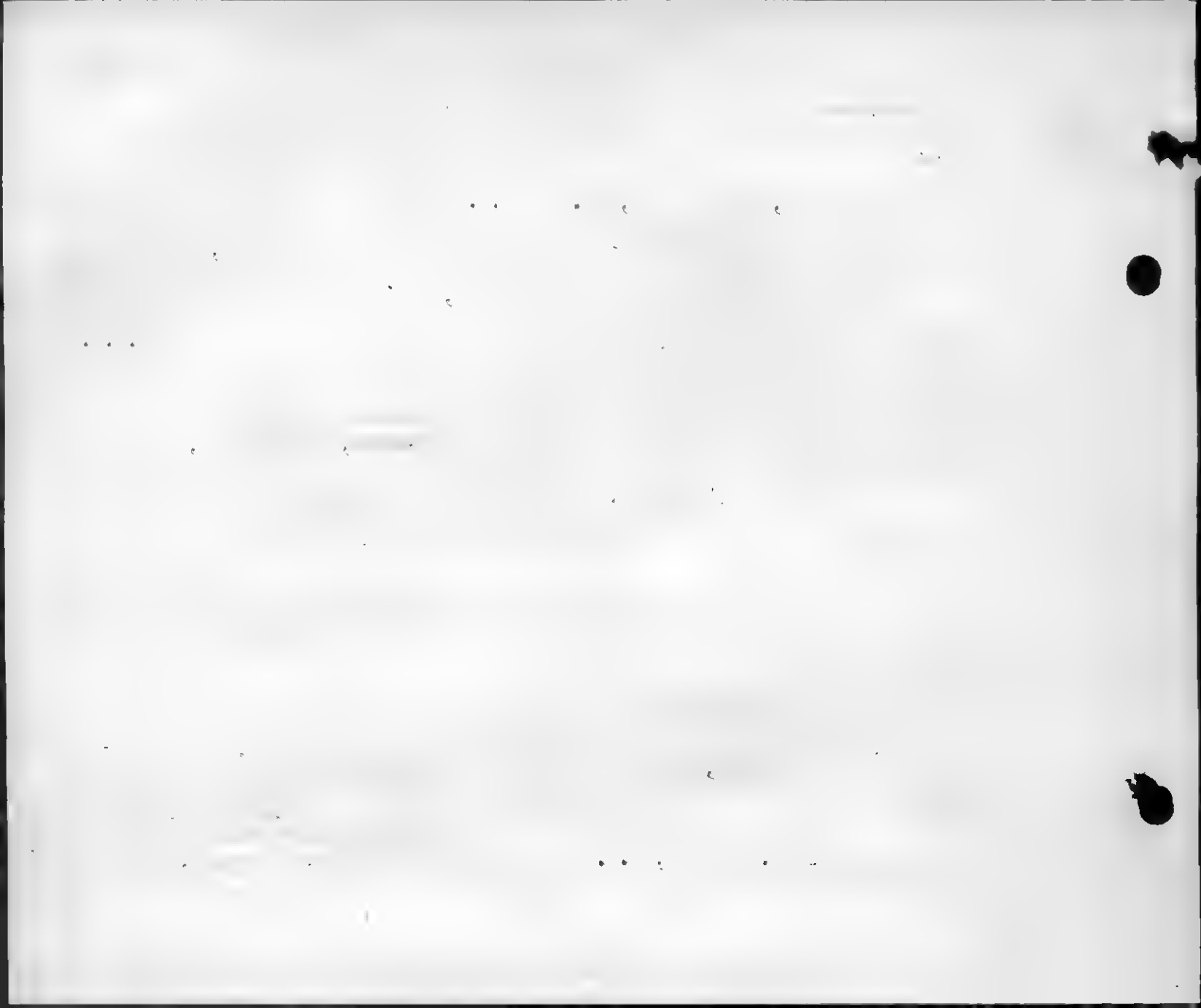
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Seneca</b>		c. LENGTH OF STAY IN 1b		3. NAME OF DECEASED (Type or print) <b>BEDA CARLINE HELGREN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 22, 1884</b>		9. AGE (In years last birthday) <b>77</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Sweeden</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>John F. Loff</b>				14. MOTHER'S MAIDEN NAME <b>Wilamena Carolina</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs Chas. E. Clark-Item # 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALNUTRITION</b> <b>11X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <b>Linitus PLASTICA</b> DUE TO (c) <b>CARCINOMA OF STOMACH</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b> <b>3 MONTH</b> <b>5 MONTH</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour <b>o m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June 1958</b> to <b>11 June 1961</b> , that I last saw the deceased alive on <b>10 June 1961</b> , and that death occurred on <b>2:30 AM</b> , from the causes and on the date stated above. <b>John G. Fawcett</b> M.D. <b>DAWSONVILLE</b> <b>6/11/61</b> ADDRESS (Street, city or town, state) <b>P.O. Boy DS, Md.</b> DATE SIGNED									
ACTUAL SIGNATURE									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)			
<b>Burial</b>		<b>6/13/61</b>		<b>Darnestown Church Cem.</b>		<b>Darnestown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
						DATE <b>JUN 12 1961</b>			



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be refiled at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>223 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>					d. STREET ADDRESS <b>P.O. Box 76</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elaine Marie Hessey</b>					4. DATE OF DEATH Month Day Year <b>June 11, 19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1946</b>		9. AGE (In years less birthday) yrs <b>14</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Edwin Hessey</b>					14. MOTHER'S MAIDEN NAME <b>Gladys Biggs</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, (If yes, give war or dates of service,) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACRANIAL HEMORRHAGE</b> <b>204-3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ACUTE MYELOGENOUS LEUKEMIA</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 HRS</b> <b>18 MOS</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 31, 1960</b> to <b>June 11, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 11, 1961</b> , and that death occurred at <b>1:15AM</b> from the causes and on the date stated above										
22a. SIGNATURE <b>Emanuel S. Hellman</b> M.D.					22b. DATE SIGNED <b>6/11/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Emanuel S. Hellman, M.D.</b>					22d. ADDRESS <b>The Clinical Center Bethesda 14, National Institutes Of Health, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 13, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Nr. Chesapeake City, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Donald M. De</b>					ADDRESS <b>Elkton, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	





TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

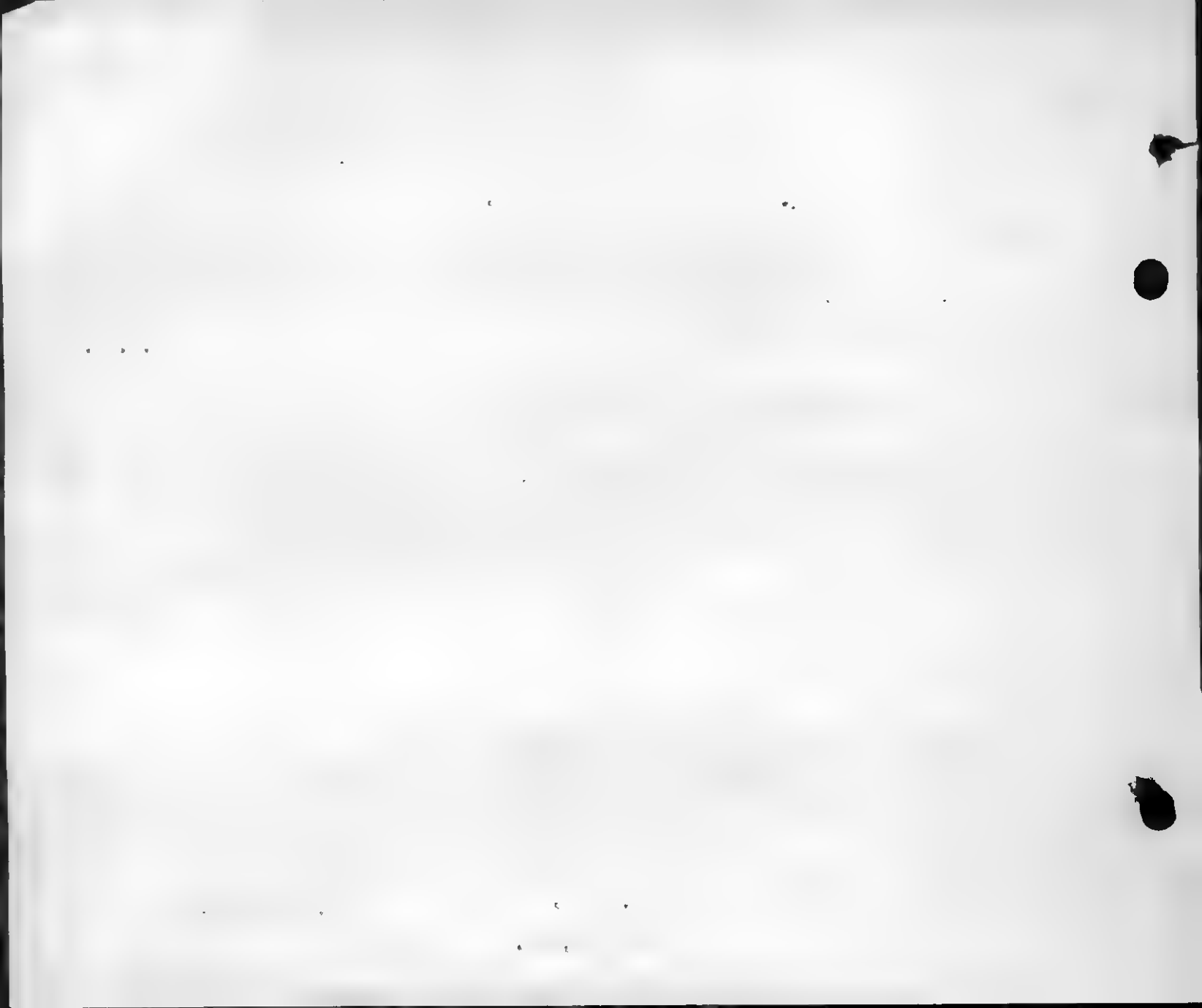
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6944

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06931

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Box 108 Olney,</b> d. STREET ADDRESS <b>Box 108</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret,</b> Middle <b>Elgar</b> Last <b>Hill</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/21/1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Messiah Addison</b>		14. MOTHER'S MAIDEN NAME <b>Annie Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Hospital Records</b> Address <b>Olney Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>191.5</b> DUE TO <b>Pathological Fracture - Vertebrae - pubis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Epidermoid Carcinoma Grade II</b> (c) <b>Anus-rectal Region - inclusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/21</b> to <b>6/26</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6/26</b> , 19 <b>61</b> , and that death occurred at <b>6:25 PM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>6/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M. D.,</b>		22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/1/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion,</b>	23d. LOCATION (City, town, or county) (State) <b>Mt. Zion, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Swenden</b> ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 30 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0045

## CERTIFICATE OF DEATH

Reg. Dist. No. 06932

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>41</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Sanitarium</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>41 Kensington</b>	
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Sanitarium</b>		d. STREET ADDRESS <b>9709 E. Bexhill Dr.</b>	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Michael</b> First Middle <b>Holland</b> Last		4. DATE OF DEATH <b>June</b> Month <b>17</b> Day <b>1961</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR <b>9</b> Months <b>15</b> Days	IF UNDER 24 HRS <b>15</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>London, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. Naturalized.</b>	
13. FATHER'S NAME <b>John Holland</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Sullivan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Daughter</b> Address <b>Same as Item #2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Constrictive Heart failure</b> DUE TO <b>Coronary insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Cerebral thrombosis + Anemia</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral thrombosis + Anemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/27, 1960</b> , to <b>present</b> , that I last saw the deceased alive on <b>6/16, 1961</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above.			
21. I certify that I attended the deceased from <b>12/27, 1960</b> , to <b>present</b> , that I last saw the deceased alive on <b>6/16, 1961</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>8805 Conn. Ave. C/1761</b>	
21. I certify that I attended the deceased from <b>12/27, 1960</b> , to <b>present</b> , that I last saw the deceased alive on <b>6/16, 1961</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above.		DATE SIGNED <b>6/17/61</b>	
ACTUAL SIGNATURE <b>John B. Umhau</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOHN B. UMHAU</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 6-17-61</b>		22b. DATE THEREOF <b>6-17-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Yeadon, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: 3. ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

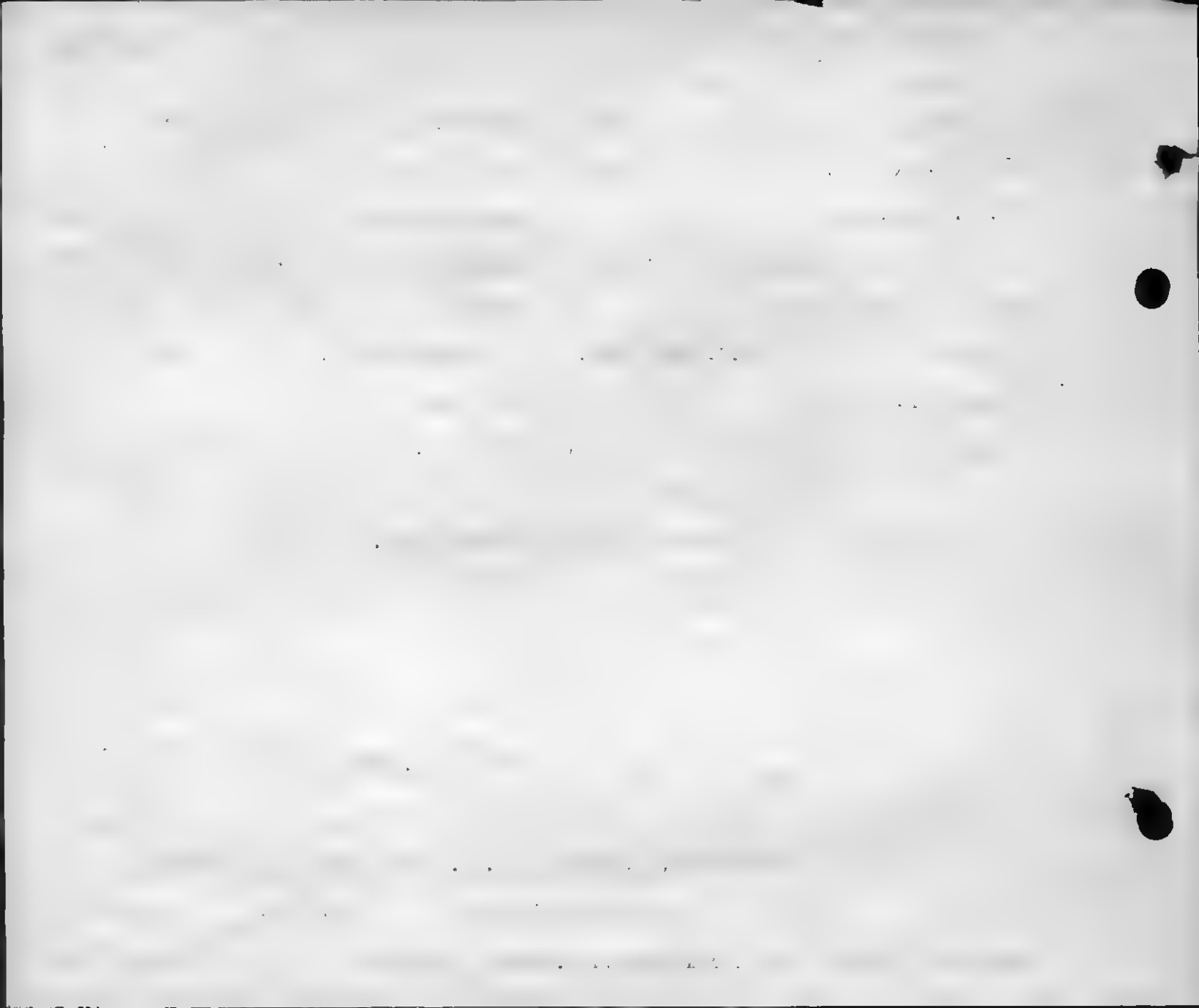
## CERTIFICATE OF DEATH

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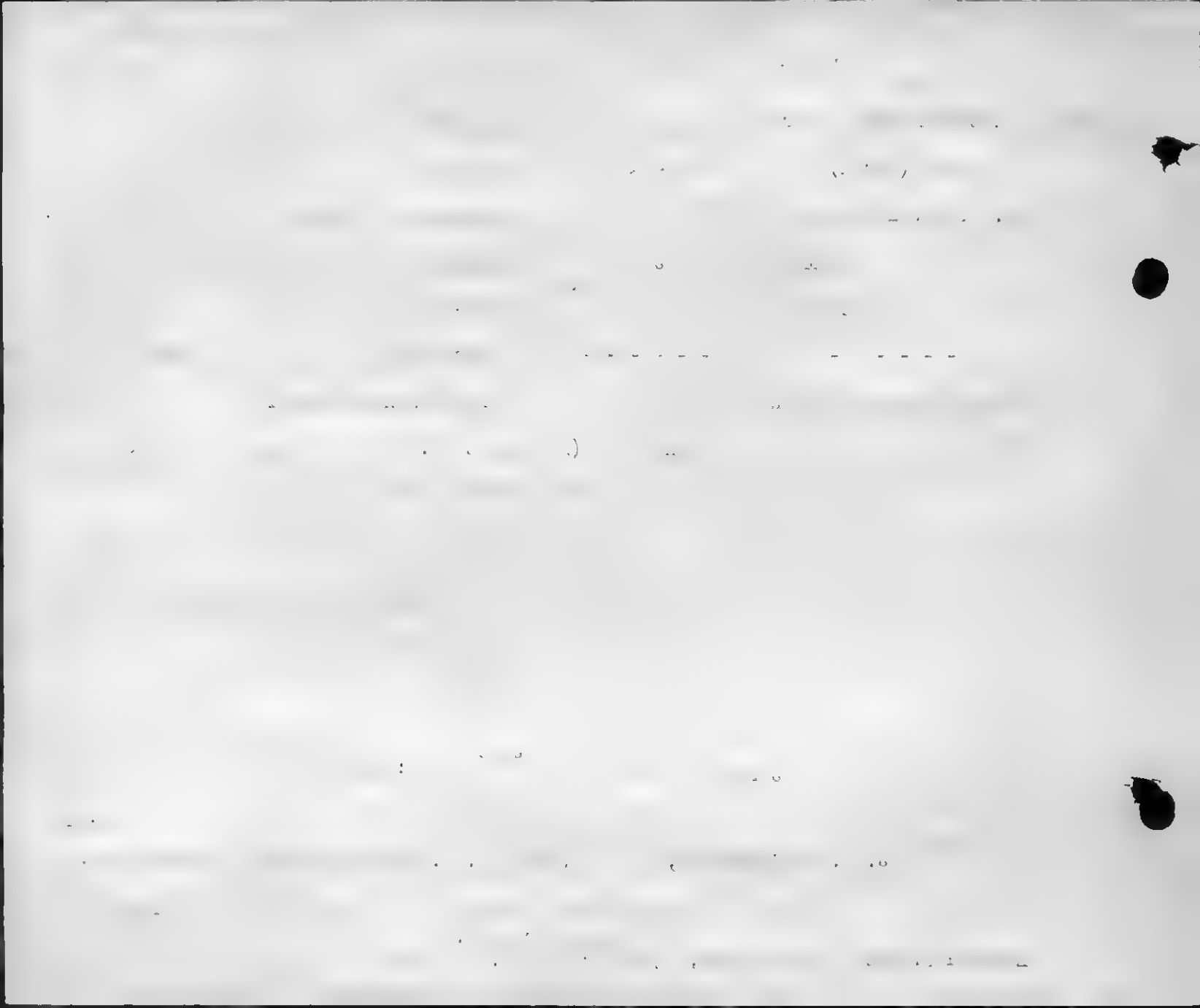
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<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY N 1b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>6807 Randolph St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Raymond Henry HOOPER</b> 5. SEX <b>Male</b> 6. COLOR OR RACE <b>Caucasian</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2-20-00</b> <b>9. AGE</b> (In years) <b>61</b> yrs <b>June 9 19 61</b> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Fire Dept.</b> 11. BIRTHPLACE (City & State, or foreign country) <b>Washington, D. C.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William H. HOOPER</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes WWI</b> <b>16. SOCIAL SECURITY NO.</b> <b>577-46-7333</b> <b>17. INFORMANT</b> <b>(S) Raymond E. Hooper, same as #2 above</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Rosa REECE</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO (b) <b>Pneumonia and Chronic Emphysema.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 2 1961</b> to <b>June 9 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 9 1961</b> , and that death occurred at <b>1:03 PM</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Paul G. LINAWEAVER, LT, MD, USN</b>		<b>22b. DATE SIGNED</b> <b>6-9-61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>6-13-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b> <b>23d. LOCATION (City, town or county) (State)</b> <b>Arlington Virginia</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Matthewly Funeral Home, 131 11th St., SE, WashDC</b> <b>24a. ADDRESS</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUN 13 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>	

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15M 9/60









# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

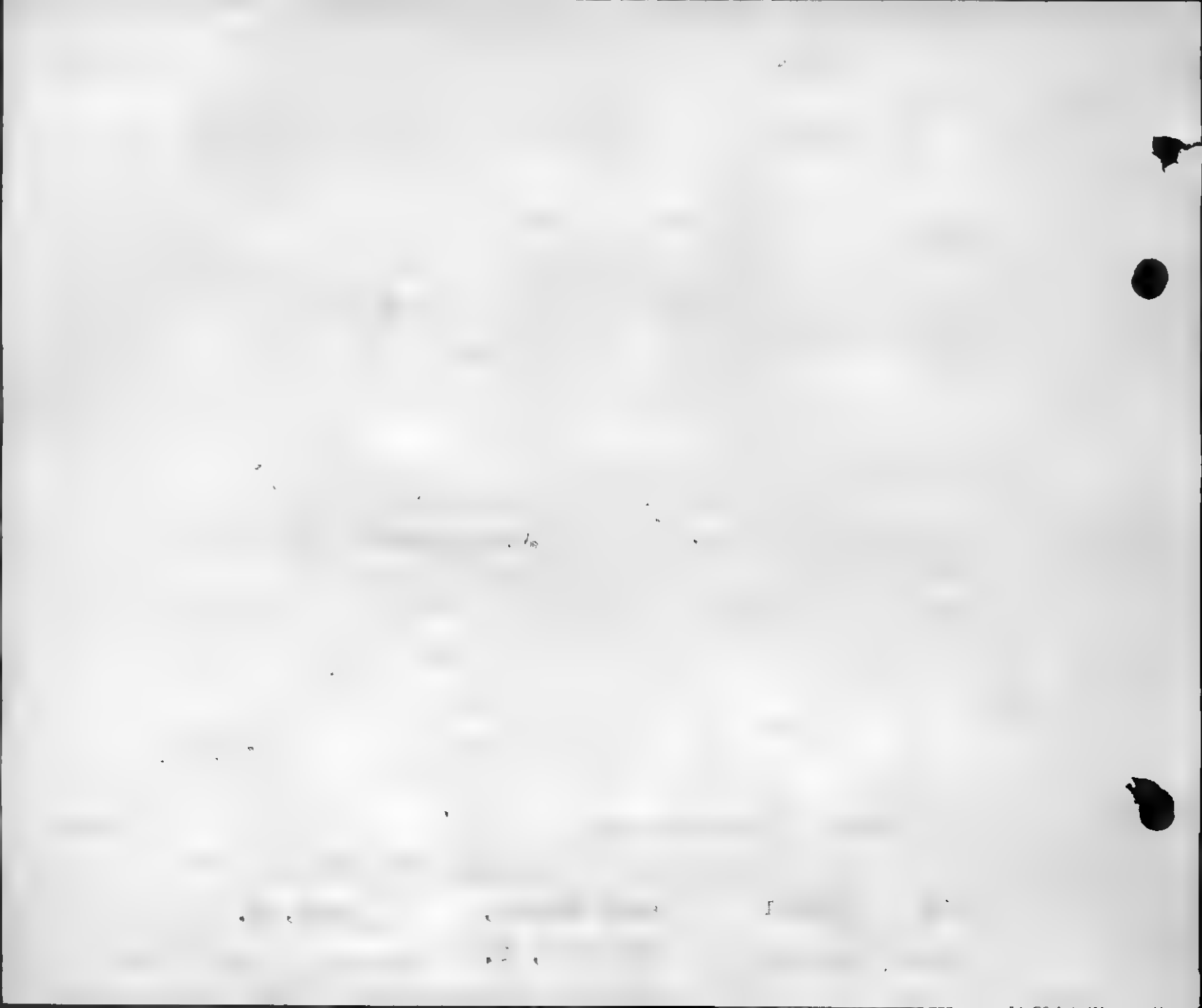
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06935

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Brookville</u> d. STREET ADDRESS <u>Box 72 - Rt. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>George Samuel Howard</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Colored</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>4. DATE OF DEATH</b> <u>JUNE 10 1961</u> Month Day Year <b>8. DATE OF BIRTH</b> <u>11-25-1896</u> last birthday Months Days Hours Min. <b>9. AGE</b> (In years) <u>64</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>GREENBURY HOWARD</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		<b>14. MOTHER'S MAIDEN NAME</b> <u>REBECCA NETTLES</u> <b>17. INFORMANT</b> <u>Stonewall Ave. Rockville, Md.</u> <u>Harriet C. Jenkins (daughter)</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small Intestinal obstruction (ileus)</u> <u>570.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Volvulus of small Bowel Mesentery</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>6/4</u> <b>1961</b> <b>to</b> <u>6/10</u> <b>1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <u>6/9</u> <b>1961</b> , <b>and that death occurred</b> <u>5:25 PM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Arthur F. Woodward</u> <b>22c. PHYSICIAN'S NAME</b> (Type)		<b>22b. DATE SIGNED</b> <u>6/11/61</u> <b>22d. ADDRESS</b> <u>Rockville - Md.</u>	
<b>23a. BURIAL, CREMATION, REINTERMENT</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>6/14/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Family Cemetery,</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Unity, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Snowden</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE JUN 20 '61</u>	
<b>ADDRESS</b> <u>Rockville, Md.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

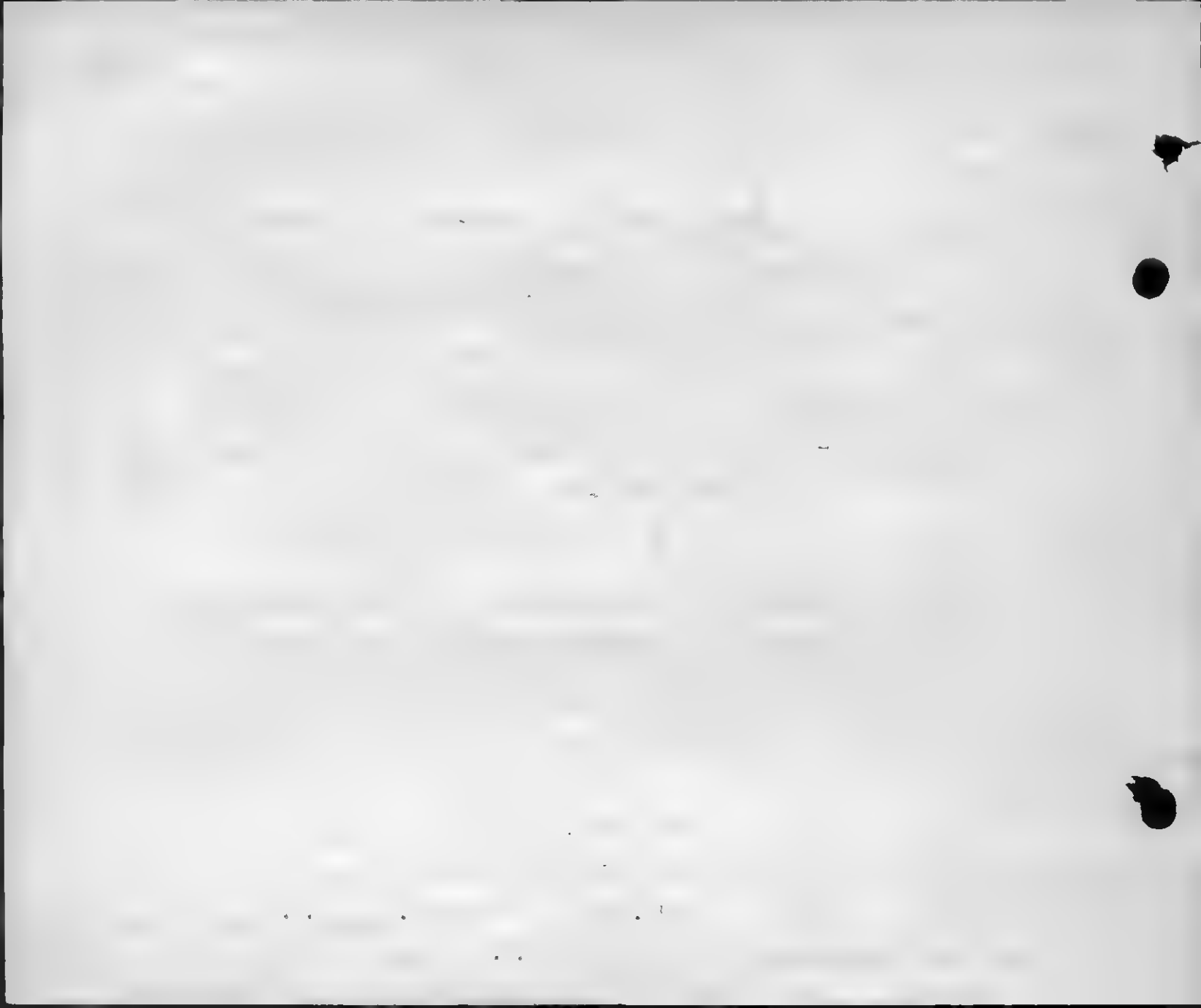
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b _____		d. STREET ADDRESS <u>1225 Missouri Ave NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dora Inoff</u>		DATE OF DEATH <u>June 1, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-1881</u>
9. AGE (In years last birthday) <u>86</u> Yrs.		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>H. Crutcher</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Nursing Home Record</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>321X</u> IMMEDIATE CAUSE (a) <u>Respiratory failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebral vascular accident</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 day</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left hip at home about 3 m. ago</u>			
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brounhart</u>		DATE SIGNED <u>6-1-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROUHART</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Capital Hebrew Cem.</u>		22d. LOCATION (City, town, or country) <u>D.C.</u>	
23. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		24. REC'D BY REGISTRAR <u>JUN 5 '61</u>	
ADDRESS <u>4217 9th Street N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Funn</u>	



FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed within 72 hours after death. The certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed within 72 hours after death. The certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed within 72 hours after death.

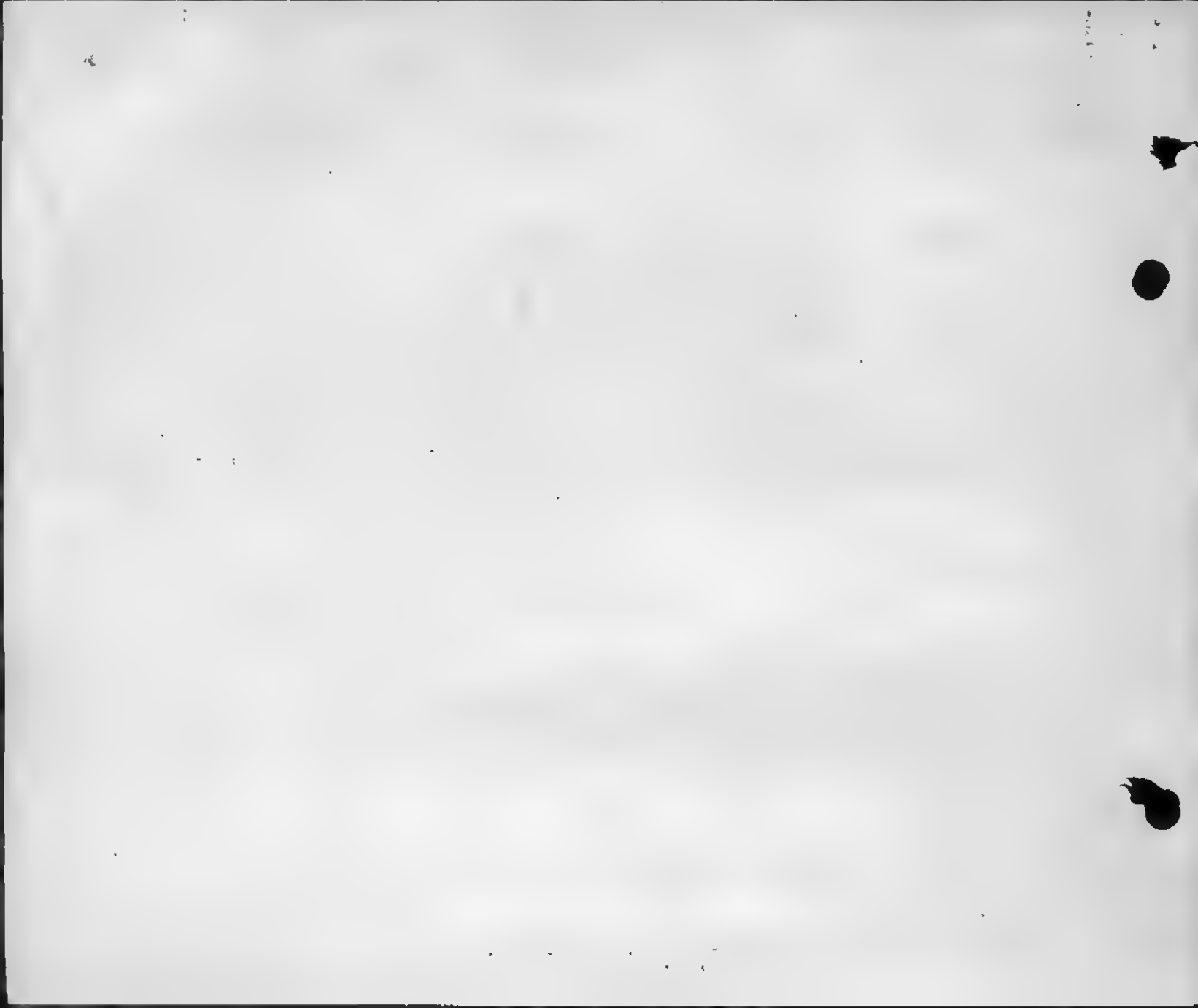
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6950

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06937

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>			
c. LENGTH OF STAY IN 1b <u>1 mo</u>				d. STREET ADDRESS <u>Collins Rd - Box 186</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Collins Rd - Box 186</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Louise A. Jacob</u>				4. DATE OF DEATH <u>June 1 1961</u>			
5. SEX <u>female</u>				6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>9-28-1871</u>			
9. AGE (in years last birthday) <u>89</u> yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Pa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Michael Lutz</u>				14. MOTHER'S MAIDEN NAME <u>Hannah ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs Joseph G. Brown</u>				Address <u>714 Woodburn Rd., Rockville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bloesch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BLOESCH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>6-1-61</u>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit</u>				22b. DATE THEREOF <u>6/2/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Dunmore</u>				22d. LOCATION (City, town, or county) (State) <u>Scranton, Pennsylvania</u>			
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>DUN 5 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 290 7-3-63 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
6951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH C6938

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		
c. LENGTH OF STAY IN H <u>5 days</u>			d. STREET ADDRESS <u>4706 Hunt Avenue</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Salyer</u> Last <u>Jennings</u>			4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24, 1915</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. News &amp; World Report</u>		
11. BIRTHPLACE (State or foreign country) <u>Colorado</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Charles Jennings</u>			14. MOTHER'S MAIDEN NAME <u>Jane Salyer</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		
17. INFORMANT <u>Pauline Jennings (wife)</u>			Address <u>Same as above</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Spontaneous thrombosis of pulmonary, coronary &amp; cerebral arteries</u>					
DUE TO (b) <u>Acute Thrombocytosis following splenectomy</u>					
DUE TO (c) <u>rupture of spleen from accidental fall</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT.ON GIVEN IN PART I (a) <u>  </u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall from house roof at home</u>					
20c. TIME OF INJURY Month, Day, Year <u>10:00 PM 6-18 1961</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Cherry Chase Montg. Md</u>		20g. (County) <u>Montgomery</u> (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED <u>6-19-61</u>					
ACTUAL SIGNATURE <u>Frank J. Broschewitz</u> M.D.					
EXAMINER'S NAME (Type) <u>FRANK J. Broschewitz</u>					
Address (Street, city, town, or county) <u>  </u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/22/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
22d. LOCATION (City, town, or country) <u>Rockville, Maryland</u>		(State) <u>  </u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>					
24a. REC'D BY REG. STRAR <u>JUN 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

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economy and the state of the  
country.



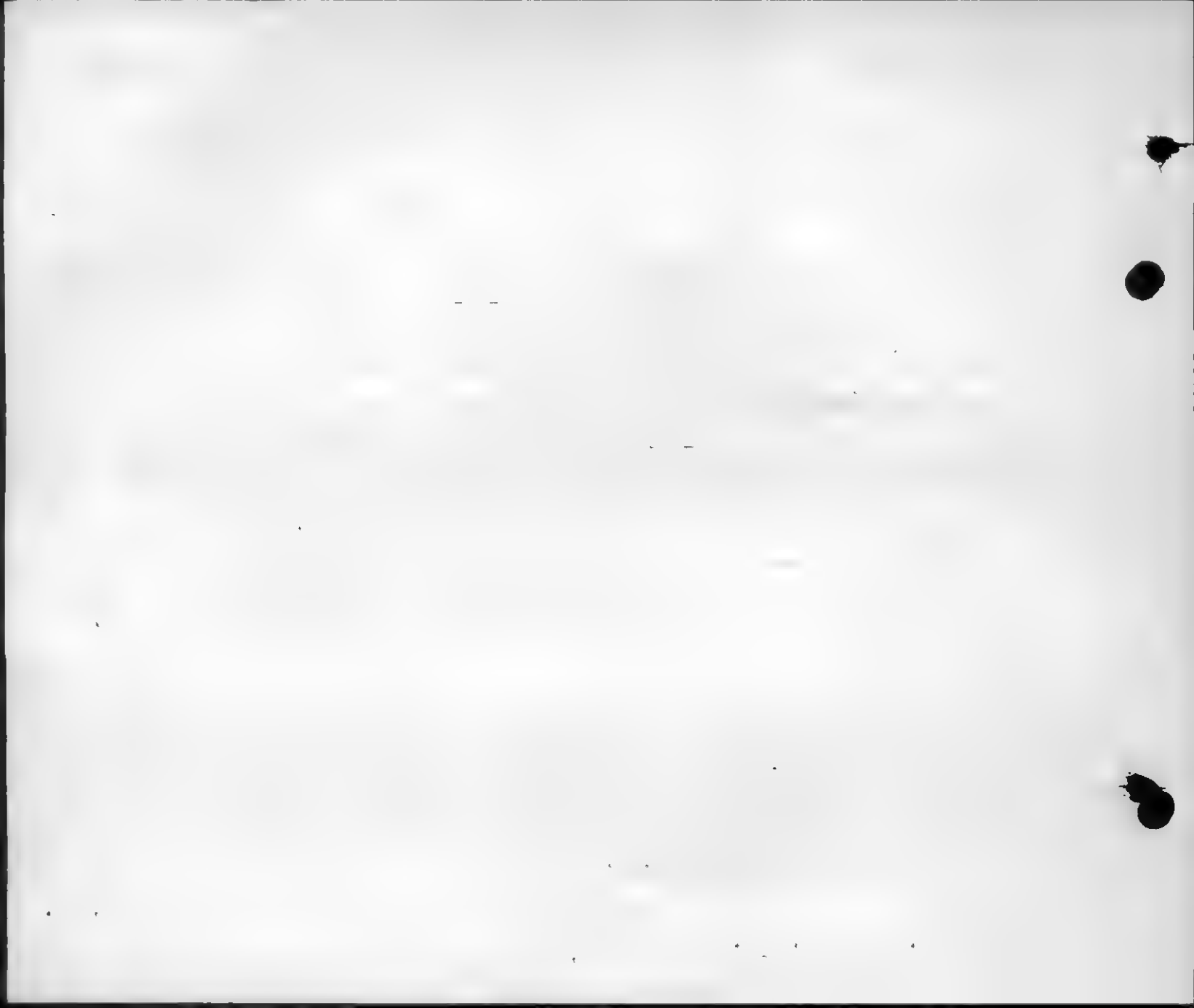
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

C952

06939

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>16 HOURS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>15500 GOOD HOPE ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET REBECCA JOHNSON</b>				4. DATE OF DEATH Month Day Year <b>JUNE 13, 19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-10-82</b>	
9. AGE (In years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Andrew Jackson HAROING</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Myers</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>219-34-8156</b>		17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PERITONITIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) <b>PERFORATION OF COMMON DUCT</b> <b>HYPERTENSIVE HEART DISEASE</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>10 DEC. 1960</b> to <b>13 JUNE 19 61</b> , that (I) (we) last saw the deceased alive on <b>13 June 19 61</b> , and that death occurred at <b>11 P.M.</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>John Bosley Ziegler</b> M.D.				22b. DATE SIGNED <b>6/14/61</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN B. ZIEGLER, M.D.</b>	
22d. ADDRESS <b>OLNEY, MARYLAND</b>							
23a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burtonsville Union Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Burtonsville, Montgomery, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>DATE JUN 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William E. Hines</b>	
ADDRESS <b>8434 Georgia Avenue Silver Spring, Maryland</b>							

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6953

06940

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6631 Eastern Ave</u>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anna Marie (MAMIE) Tokumsen</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>27</u> , Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12-10-72</u>							
<b>9. AGE</b> (In years last birthday) <u>88</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Postal Service</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Denmark</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Mads Tokumsen</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Karen Maria Nelson</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO</b> <u>Hospital Records</u>		<b>17. INFORMANT</b> Address <u>Hospital Records</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 44 3X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> (c), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>CONGESTIVE HEART FAILURE</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)							
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>17 JUNE, 1961</u> , <b>to</b> <u>27 JUNE, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>26 JUNE, 1961</u> , <b>and that death occurred at</b> <u>7:30 PM</u> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Morrill C. Quinnan Jr.</u>		<b>22b. DATE SIGNED</b> <u>6-27-61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>MORRILL C. QUINNAN, JR.</u>							
<b>22d. ADDRESS</b> <u>704 Drovershire Road Takoma Park, Md.</u>		<b>22e. REC'D BY REGISTRAR</b>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>June 29, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Alexand Cemetery</u>							
<b>23d. LOCATION</b> (City, town or county) <u>Washington</u>		<b>(State)</b> <u>D.C.</u>		<b>23e. REGISTRAR'S SIGNATURE</b> <u>Arthur Walters</u>							
<b>23f. ADDRESS</b> <u>254 Canal St NW</u>		<b>23g. DATE</b> <u>JUN 30 '61</u>		<b>23h. REGISTRAR'S SIGNATURE</b> <u>Charles E. Thomas</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.



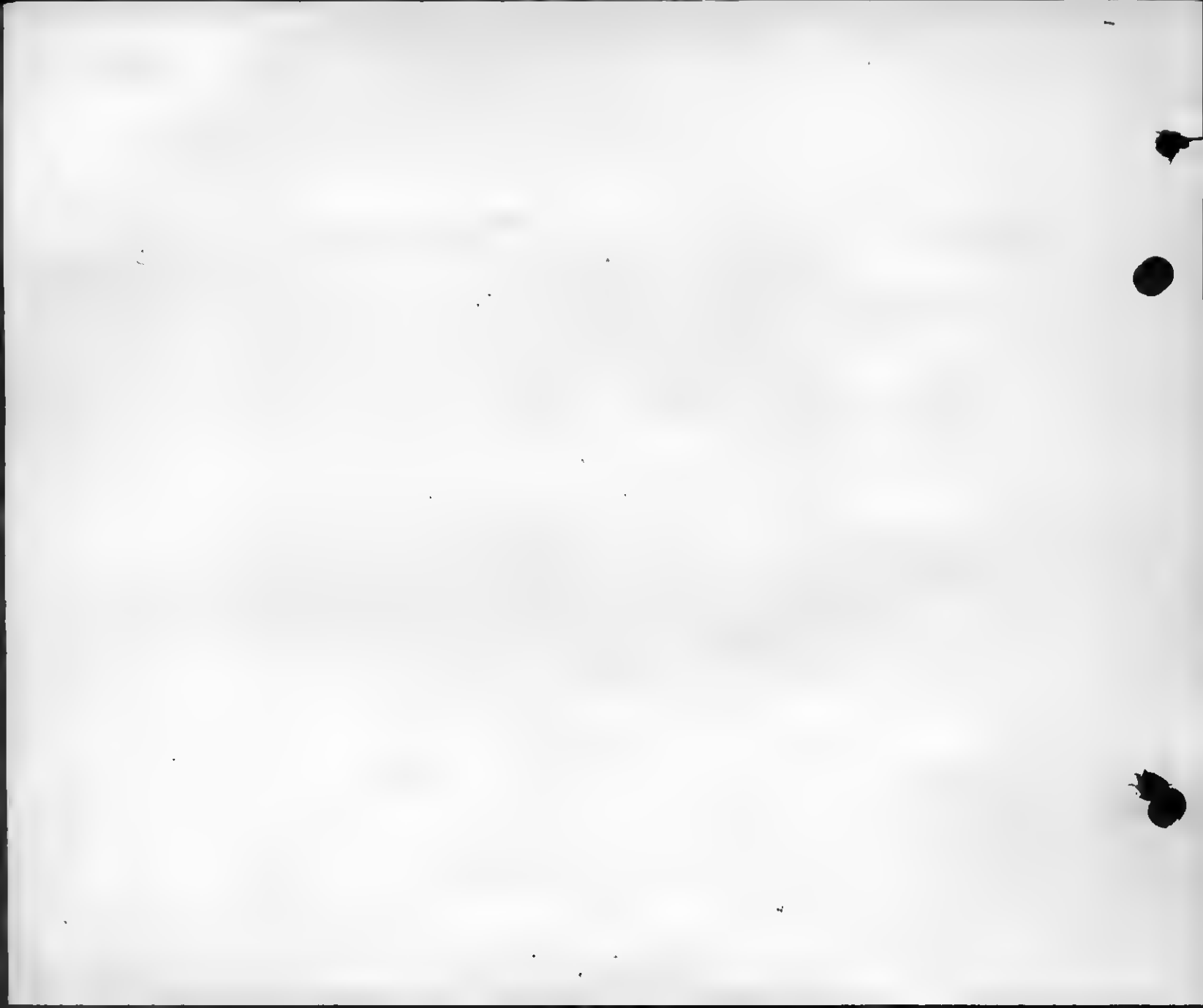
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6954

66941

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>Route #2</b>			
3. NAME OF DECEASED (Type or print) <b>Betty A. Jones</b>				4. DATE OF DEATH Month <b>6</b> Day <b>19</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/27/02</b>		9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.	IF UNDER 24 HRS Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hammond</b>				14. MOTHER'S MAIDEN NAME <b>Billy Ann Helton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Henry B. Jones / Same As Above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Spinal Hemorrhage</b> <b>ix</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>6/8</b> to <b>6/13</b> 19 <b>61</b> that (I/we) last saw the deceased alive on <b>6/12</b> 19 <b>61</b> and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>H.C. McGinnis</b>				22b. ADDRESS <b>Rockville, Md.</b>			
22c. PHYSICIAN'S NAME (Type) <b>H.C. McGinnis</b>				22d. ADDRESS <b>Rockville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville, Montgomery, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home</b>				25a. REC'D BY REGISTRAR <b>JUN 19 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



ENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
 6955  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

06942

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, write institution. If residence before admission, write residence before admission.) a. STATE <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
c. LENGTH OF STAY IN 1b <b>4 1/2</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Hosp. &amp; Sant.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS <b>1519--White Pl., S.E.</b>			
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>PECK</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1st</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 8, 1884</b>	
9. AGE (In years last birthday) <b>77</b> yrs		10. UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.		11. UNDER 24 HRS Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Boarding Home</b>			
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Galusha A. Peck</b>				14. MOTHER'S MAIDEN NAME <b>Susan Mertz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>1519--White Pl SE Wash. DC</b>			
17. INFORMANT <b>Frank S. Peck</b>				Address <b>1519--White Pl SE Wash. DC</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Large bed sores, malnutrition</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Large bed sores, malnutrition</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 26, 1961</b> to <b>June 1, 1961</b> , that (we) last saw the deceased alive on <b>June 1, 1961</b> , and that death occurred at <b>4:15 AM</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>Norman H. Rubenstein</b>				22b. DATE SIGNED <b>6/1/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Norman H. Rubenstein, M.D.</b>				22d. ADDRESS <b>6480 N.H. Ave. Takoma Park, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>June 3, 1961</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simon Bros.</b>				25a. REC'D BY REGISTRAR <b>DATE JUN 5 '61</b>			
ADDRESS <b>1661--Good Hope Rd., SE Washington 20 DC</b>				25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>			

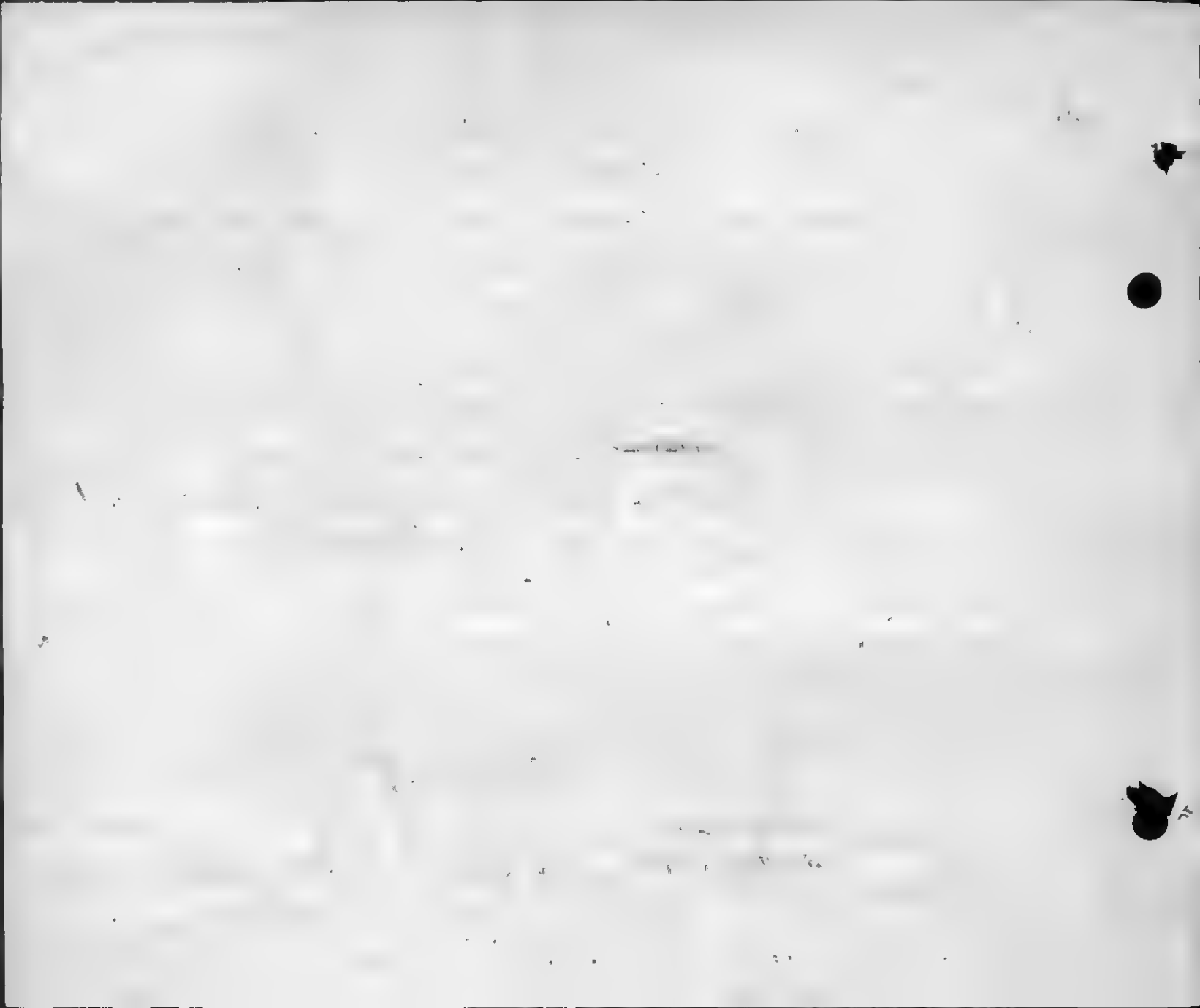




1  
The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6955  
69544  
MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1868 Columbia Rd. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Ola Elizabeth</u> First Middle Last		4. DATE OF DEATH <u>June 3 1961</u> Month Day Year	
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-14-86</u> Last	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>William F. Morris</u>		14. MOTHER'S MAIDEN NAME <u>Letitia Longfellow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-16-2933</u>	
17. INFORMANT <u>Hospital Records</u> Address		18. CAUSE OF DEATH (Enter only one cause or line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure (Acute Decompensation)</u> DUE TO (b) <u>Cardio-Vascular-Renal Syndrome</u> DUE TO (c) <u>Seizures</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Varicose ulcer - Right lower leg</u>		22. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
23. TIME OF INJURY Month, Day, Year <u>May 1 1961</u> Hour a.m. <u>3</u> p.m. <u>3</u>		24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
25. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		26. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State) <u>D.C.</u>	
27. I certify that (I) (this hospital) attended the deceased from <u>June 2 1961</u> to <u>June 3 1961</u> , that (I) (we) last saw the deceased alive on <u>June 2 1961</u> , and that death occurred at <u>3:30</u> M. from the causes and on the date stated above.		28. SIGNATURE <u>Lynwood Heiges</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
29. PHYSICIAN'S NAME (Type) <u>LYNWOOD HEIGES</u>		30. ADDRESS <u>6940 Emily Branch Rd. N.W.</u>	
31. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		32. DATE THEREOF <u>6/5/61</u>	
33. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		34. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State) <u>D.C.</u>	
35. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.</u>		36. ADDRESS <u>Wash, D.C.</u>	
37. REC'D BY REGISTRAR <u>JUN 5 '61</u>		38. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06945

0957

<b>1. PLACE OF DEATH</b> a. COUNTY: <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): <u>Bethesda</u> c. LENGTH OF STAY IN: <u>7 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE: <u>D.C.</u> b. COUNTY: _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): <u>Washington</u> d. STREET ADDRESS: <u>6641 32nd Street NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Annie Malkin Joyce</u>				<b>4. DATE OF DEATH</b> Month: <u>June</u> Day: <u>20</u> Year: <u>1961</u>			
<b>5. SEX</b> : <u>Female</u> <b>6. COLOR OR RACE</b> : <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> : <u>Dec 9 1871</u> <b>9. AGE</b> (In years last birthday): <u>89</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> : _____		<b>11. BIRTHPLACE</b> (County & State, or foreign country): <u>Connecticut</u>			
<b>13. FATHER'S NAME</b> : <u>Joseph Malkin</u>				<b>14. MOTHER'S MAIDEN NAME</b> : <u>Emily Cady</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service): <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> : _____			
<b>17. INFORMANT</b> : <u>James Wallace Joyce (Son)</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): _____			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> . (Enter nature of injury in Part I or Part II of item 18.): _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year: _____ Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.): _____			
<b>20f. (City or town)</b> : _____		<b>20g. (County)</b> : _____		<b>20h. (State)</b> : _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 14 1961</u> <b>to</b> <u>June 20 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>June 19 1961</u> <b>and that death occurred at</b> <u>2:00 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> : <u>R. Raedy</u>				<b>22b. DATE SIGNED</b> : <u>June 20 1961</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> : <u>R. Raedy M.D.</u>				<b>22d. ADDRESS</b> : <u>3701 Leland ST Chevy Chase Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> : <u>Cremation</u>		<b>23b. DATE THEREOF</b> : <u>6-20-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> : <u>Cedar Hill Crematory</u>			
<b>23d. LOCATION (City, town or county)</b> : <u>Prince George Co., Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> : <u>ROBERT A. PUMPHREY</u>		<b>25a. REC'D BY REGISTRAR</b> : <u>Arthur L. Frank</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> : _____		<b>25c. DATE</b> : <u>JUN 22 '61</u>		<b>25d. ADDRESS</b> : _____			

MEDICAL CERTIFICATION

TO HOSPITAL: If retained by the hospital or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is retained by the hospital or attending physician. Page 2 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12  
6958  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
06946

1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY IN 1b 3 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San. & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission)  
a. STATE D.C.  
b. COUNTY Washington  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington  
d. STREET ADDRESS 4019 5th St. N. W.

3. NAME OF DECEASED (Type or print) James Wilson Kendall

4. DATE OF DEATH June 27 1961

5. SEX Male  
6. COLOR OR RACE White  
7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH 2-12-86  
9. AGE (In years last birthday) 75 yrs  
IF UNDER 1 YEAR: Months    Days    Hours    Min.     
IF UNDER 24 HRS: Hours    Min.   

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman - Streetcar  
10b. KIND OF BUSINESS OR INDUSTRY Virginia  
11. BIRTHPLACE (County & State, or foreign country) U.S.A.  
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Buchanan Kendall  
14. MOTHER'S NAME Isadora Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no  
16. SOCIAL SECURITY NO. 1578-10-6246  
17. INFORMANT Margaret E. Kendall same 2-d

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 260X Congestive heart failure  
DUE TO (b) Diabetes mellitus  
DUE TO (c) Hypertension  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   

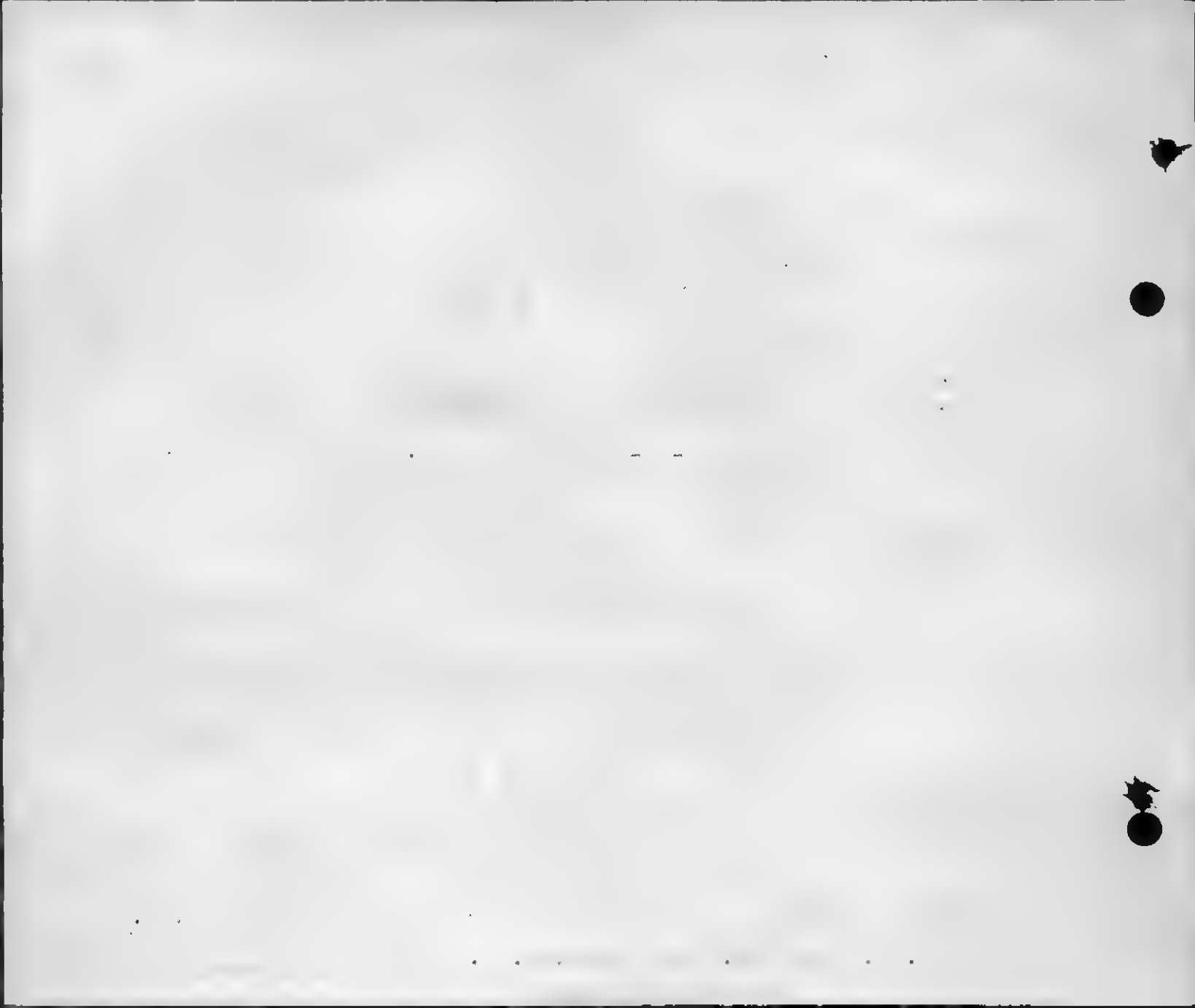
20c. TIME OF INJURY Month, Day, Year 19  
Hour a.m.    p.m.     
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)     
20f. (City or town) (County) (State)   

21. I certify that (I) (this hospital) attended the deceased from May 6, 1961, to June 27, 1961, that (I) (we) last saw the deceased alive on June 24, 1961, and that death occurred at 1:10 PM, from the causes and on the date stated above.

22a. SIGNATURE A.W. Smith  
22c. PHYSICIAN'S NAME (Type) A.W. SMITH  
22b. DATE SIGNED 6/27/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  
23b. DATE THEREOF 6/30/61  
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery  
23d. LOCATION (City, town or county) (State) Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. ADDRESS Washington, D. C.  
25a. REC'D BY REGISTRAR JUN 29 '61  
25b. REGISTRAR'S SIGNATURE Charles S. Hines



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT  
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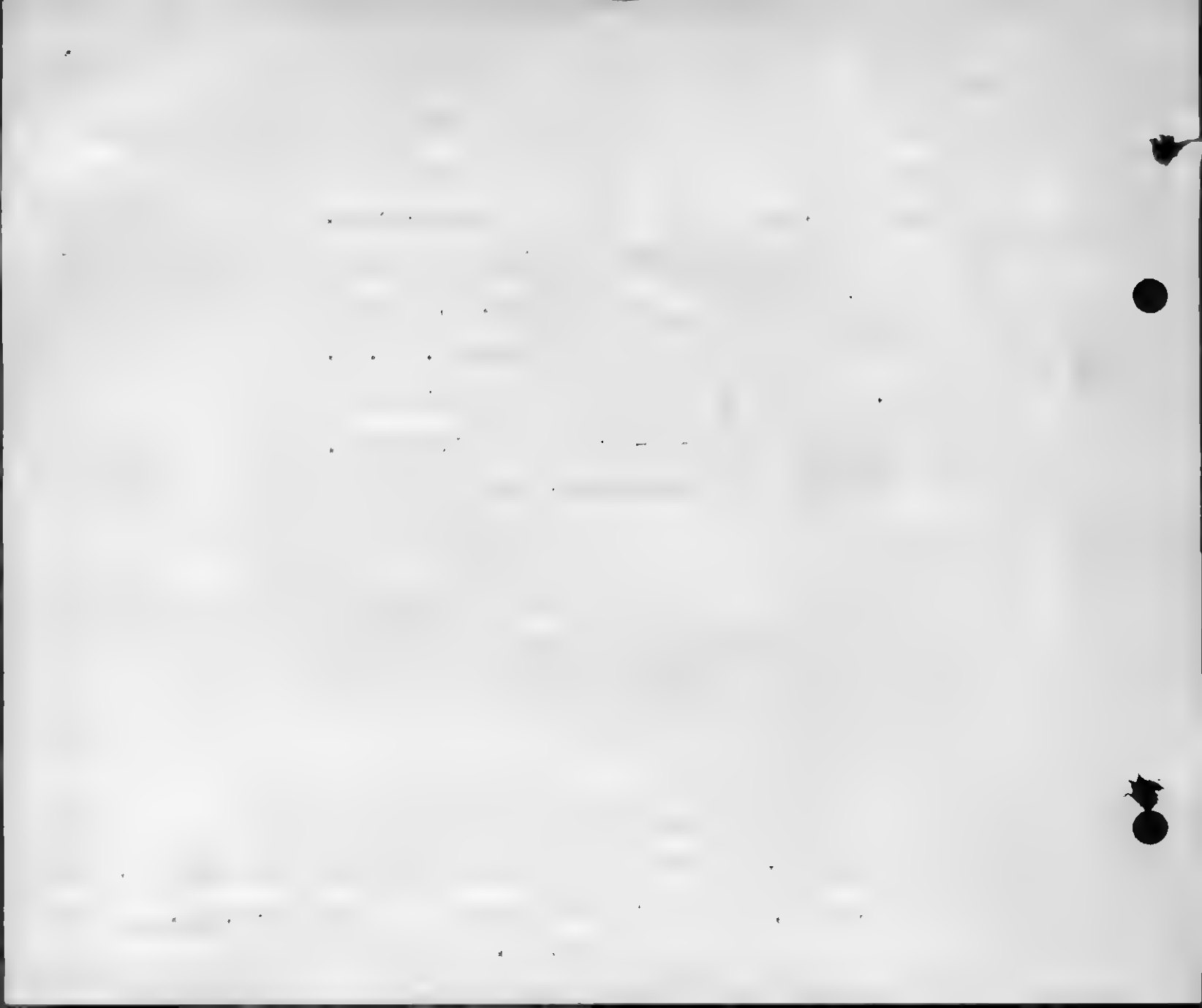
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
06947

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>30 Silver Spring</i>	
c. LENGTH OF STAY IN TB <i>14 yrs</i>		d. STREET ADDRESS <i>1021 Forest Glen Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>1021 Forest Glen Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Katherine Elizabeth Kesler</i>		4. DATE OF DEATH <i>June 15 1961</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-12-1894</i>	
9. AGE (In years last birthday) <i>66 yrs.</i>		10. IF UNDER 1 YEAR Months <i>6</i> Days <i>6</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CNA HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.C.</i>	
13. FATHER'S NAME <i>Benz Phillips</i>		14. MOTHER'S MAIDEN NAME <i>Eliz Graham</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>579-16 7488A Wm</i>	
17. INFORMANT <i>Eliz Kesler</i>		Address <i>Forest Glen 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>526X Acute congestive heart failure</i> DUE TO (b) <i>Bronchitis</i> DUE TO (c) <i>Heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET OF DEATH <i>sudden</i> <i>year</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschert</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6/18/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MT VIEW</i>		22d. LOCATION (City, town, or country) (State) <i>UNION BRIDGE MD</i>	
23. FUNERAL DIRECTOR <i>Ed Hartzler &amp; Sons</i>		24a. REC'D BY REG. STRAR <i>JUN 19 '61</i>	
ADDRESS <i>Union Bridge, Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	









## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **66949**

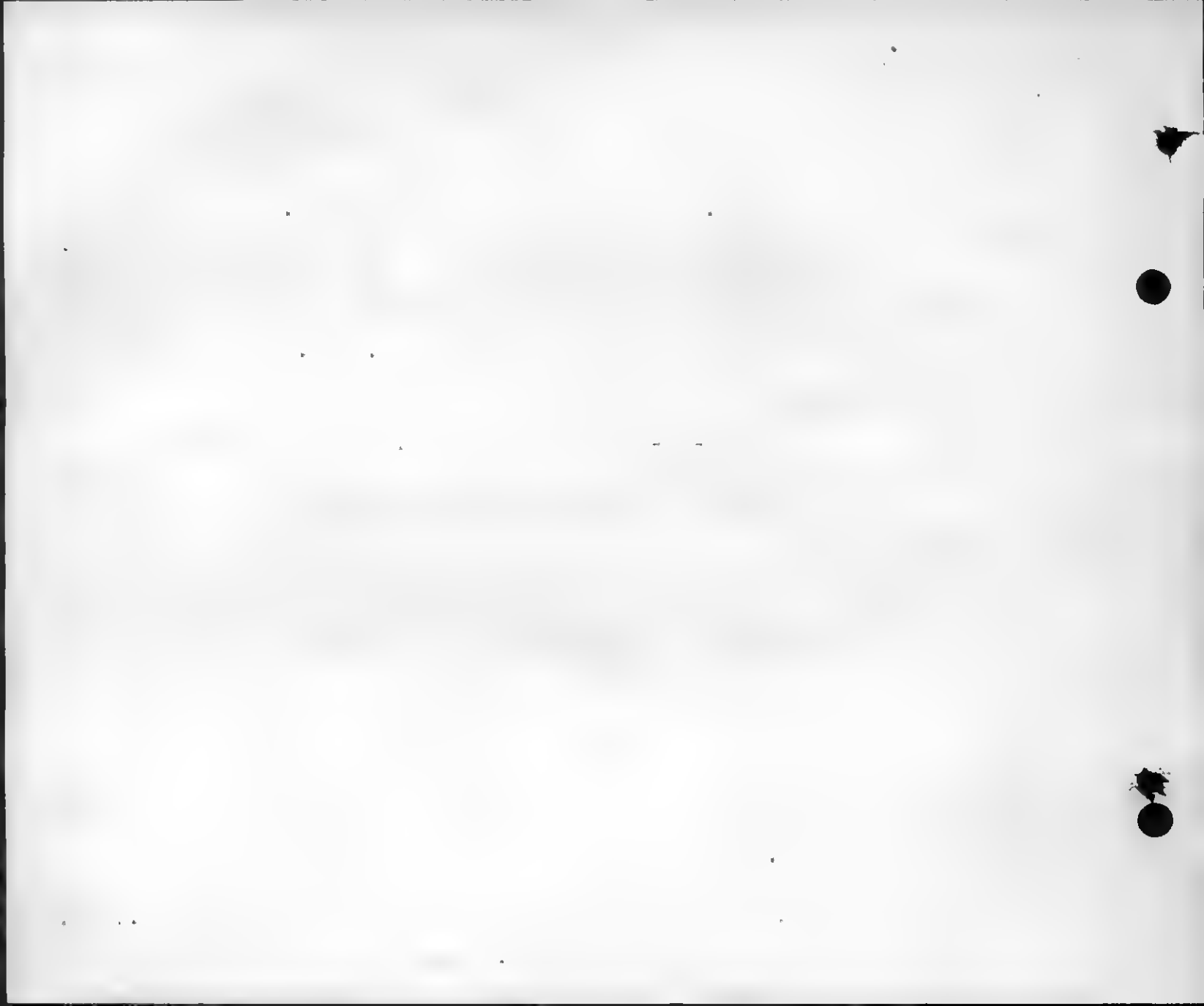
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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>				c. LENGTH OF STAY IN 1b <b>02</b> <b>Damascus</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9703 Beall Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Barton</b> Last <b>Klawonn</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1884</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Fulton Co., Pa.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		
13. FATHER'S NAME <b>Samuel Slayman</b>			14. MOTHER'S MAIDEN NAME <b>Mary Hill</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-07-4711</b>		INFORMANT <b>Mrs Harry B. Merson,</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Anteroseptal cardiovascular disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>5/18</b> , 19 <b>58</b> , to <b>6/9</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>6/4</b> , 19 <b>61</b> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6/9/61</b> ACTUAL SIGNATURE <b>James P. Kerr</b> M.D. <b>Damascus, Md.</b> PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 12, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	22d. LOCATION (City, town, or county) <b>Prince Georges Co., Md.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Johnson</b>		ADDRESS <b>Damascus, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 13 '61</b>	24b. REGISTRAR'S SIGNATURE <b>C. S. H. H. H.</b>			

Page 1 of 1

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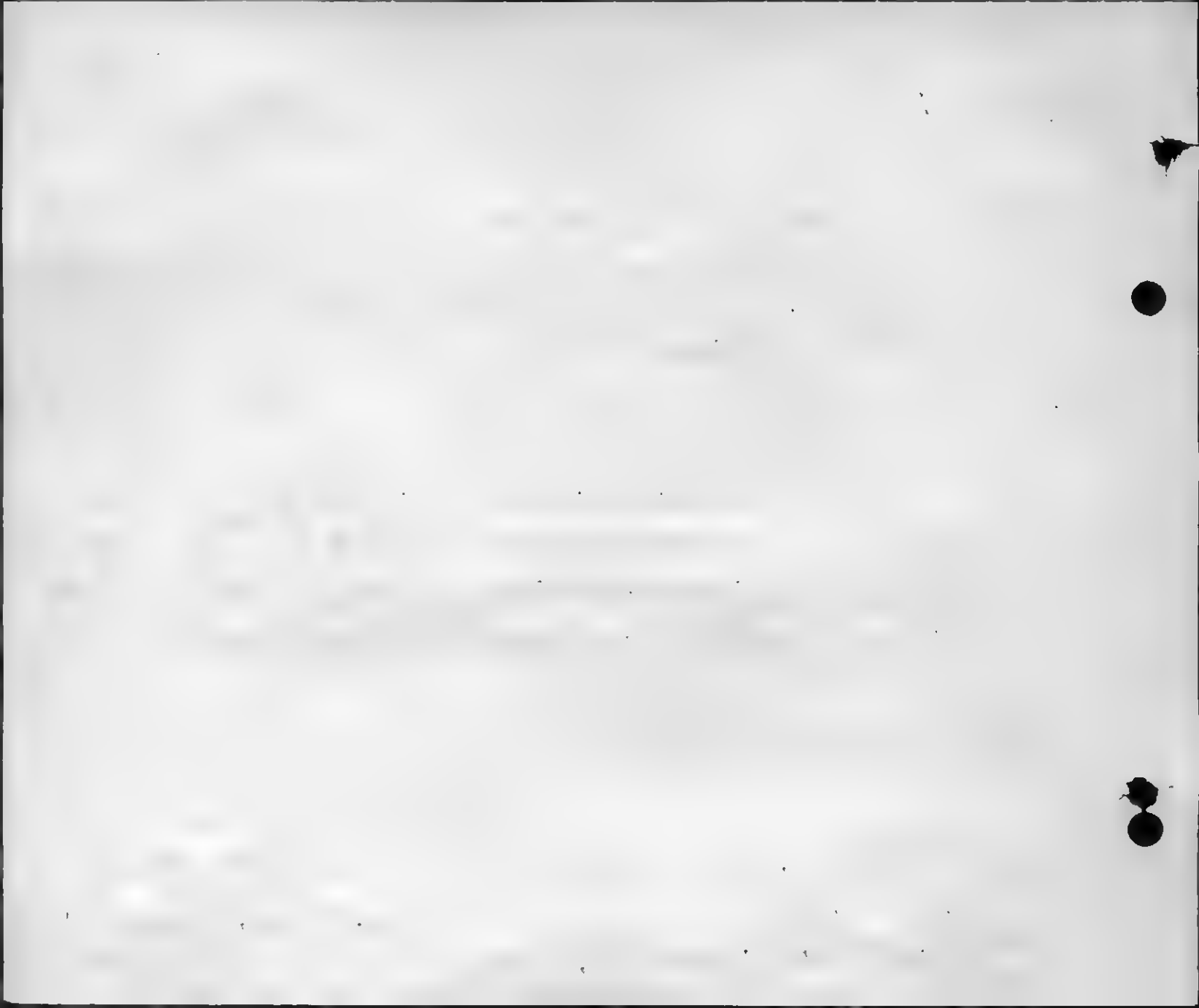
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed in 24 hours after death. It may be returned to the hospital or funeral home for filing. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



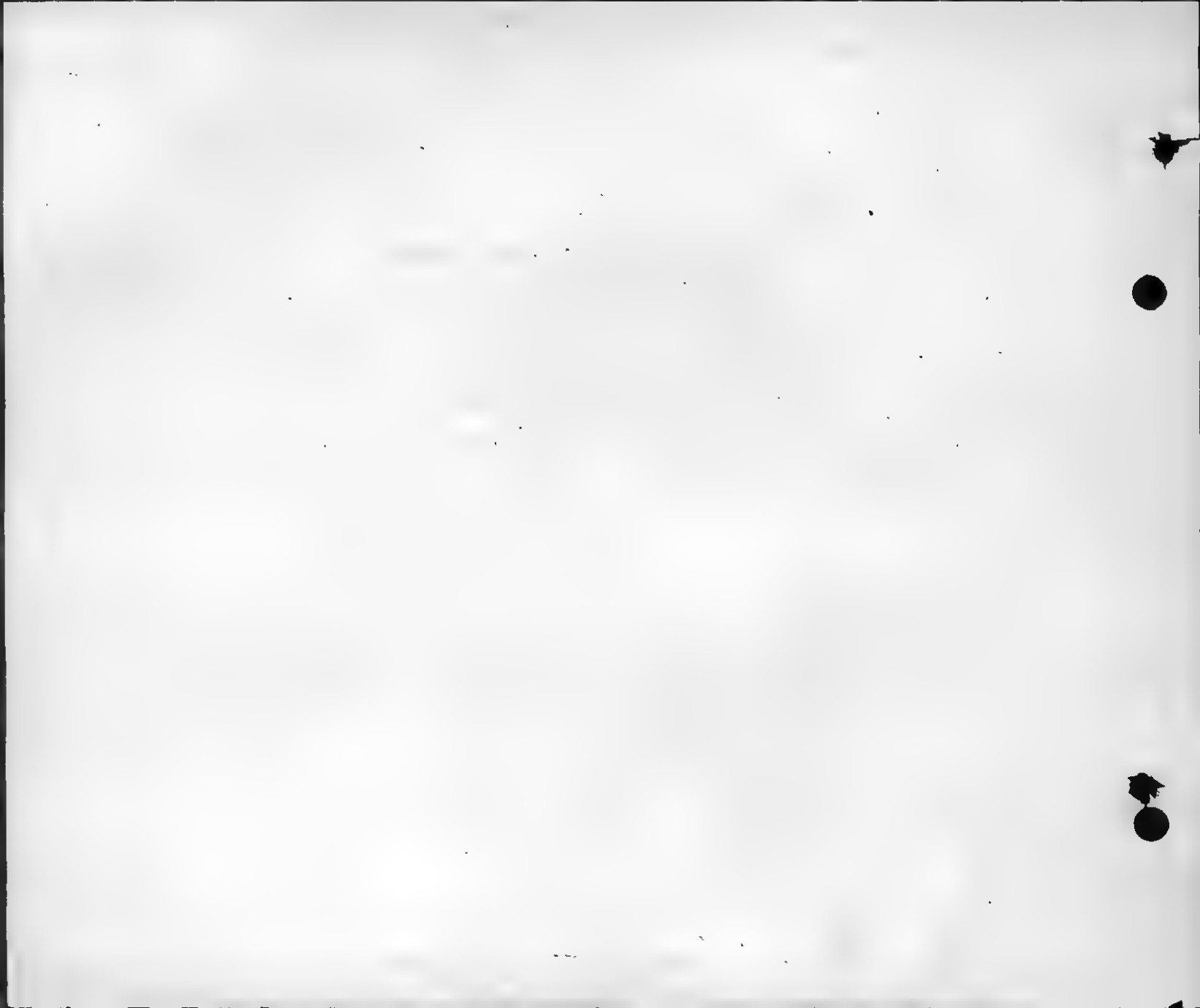
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 are retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
06950

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9407 Baltimore Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick Joseph Klund</u>		4. DATE OF DEATH <u>June 8 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-37</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Internal Revenue</u>	9. AGE (in years last birthday) <u>73</u> yrs IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>David H. Klund</u>		14. MOTHER'S MAIDEN NAME <u>Georganna Joseph</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Chart</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Pulmonary infarction and severe pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive heart disease with left ventricular hypertrophy</u> DUE TO <u>Right lung, upper lobe, early acute bronchopneumonia</u> (c) <u>left lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Six days postoperative for resection of adenocarcinoma of the colon</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1961</u> to <u>June 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 7, 1961</u> , and that death occurred at <u>11:55 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George H. McClain</u>		22b. DATE SIGNED <u>June 8-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE H. MCLAIN</u>		22d. ADDRESS <u>1746 K St. N.W. - Wash - D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/12/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Prince George's Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>June 14 '61</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	









TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY IN b. MARYLAND  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland  
b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville  
d. STREET ADDRESS 16916 Cashell Road

3. NAME OF DECEASED (Type or print) Herman Henry Ladson

4. DATE OF DEATH June 14 1961

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH May 29, 1888

9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian

10b. KIND OF BUSINESS OR INDUSTRY District of Columbia U.S.A.

11. BIRTHPLACE (County & State, or foreign country) District of Columbia U.S.A.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas A. Ladson

14. MOTHER'S MAIDEN NAME Alice Yoss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No

16. SOCIAL SECURITY NO. No

17. INFORMANT Washington Sanitarium and Hospital Records

18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5271 DUE TO Long time failure  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Severe R & L heart disease  
DUE TO Severe Pulmonary Embolism  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Interval between onset and death

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) C

20c. TIME OF INJURY Month, Day, Year 19 While at work ☐ Not While at work ☐

20d. INJURY OCCURRED 19

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 187

20f. (City or town) Rockville (County) Montgomery (State) Md.

21. I certify that (I) (this hospital) attended the deceased from 6/13/61 to 6/14/61, that (I) (we) last saw the deceased alive on 6/13/61, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE Francis W. Barber M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 6/14/61

22c. PHYSICIAN'S NAME (Type) Francis W. Barber

22d. ADDRESS 1401 13th St. N.W. Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 6-16-61

23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery

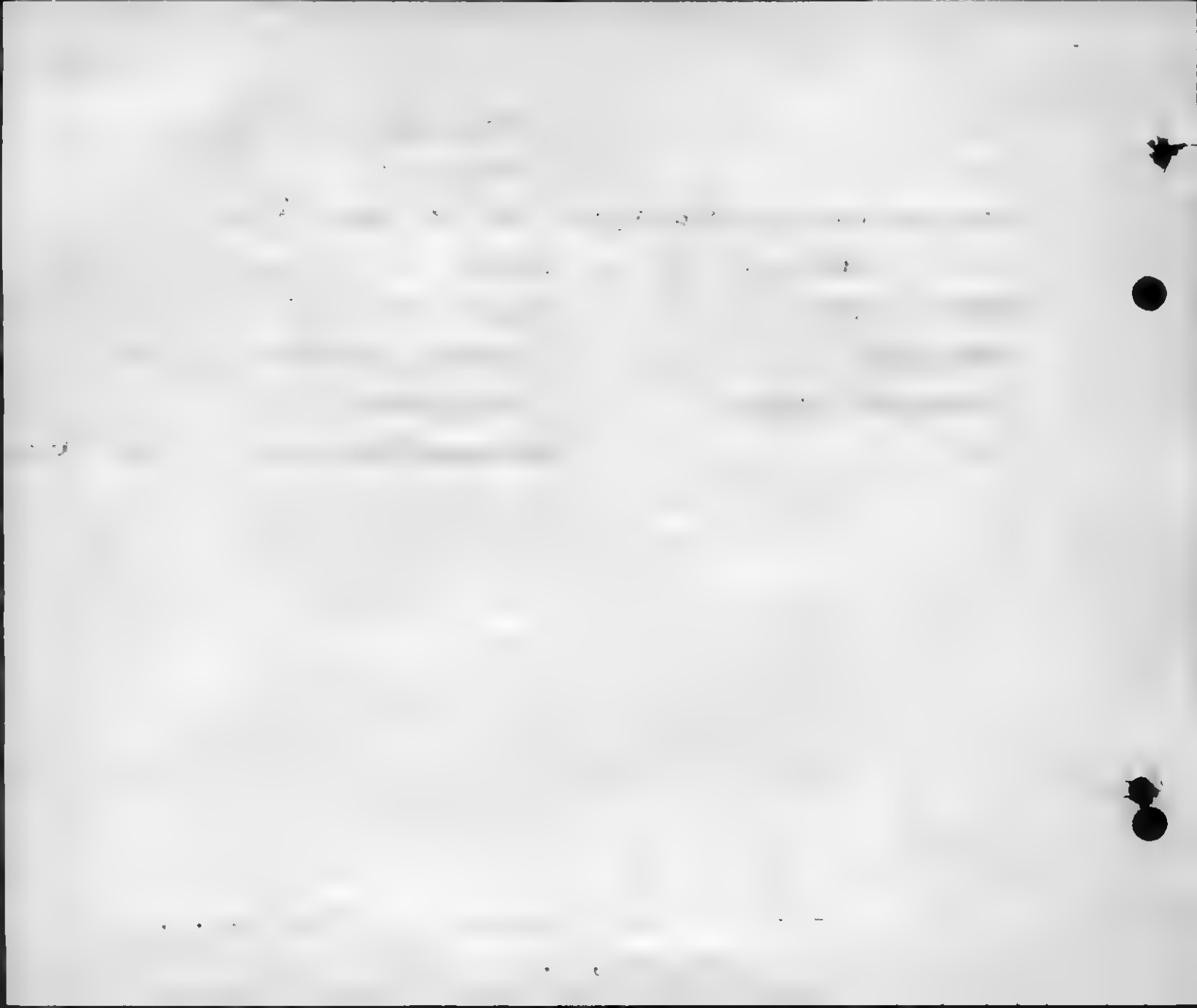
23d. LOCATION (City, town or county) Washington, D.C. (State) D.C.

24. FUNERAL DIRECTOR'S SIGNATURE Francis W. Barber ADDRESS Laytonsville, Md.

25a. REC'D BY REGISTRAR Arthur S. Thomas

25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

DATE JUN 19 1961



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

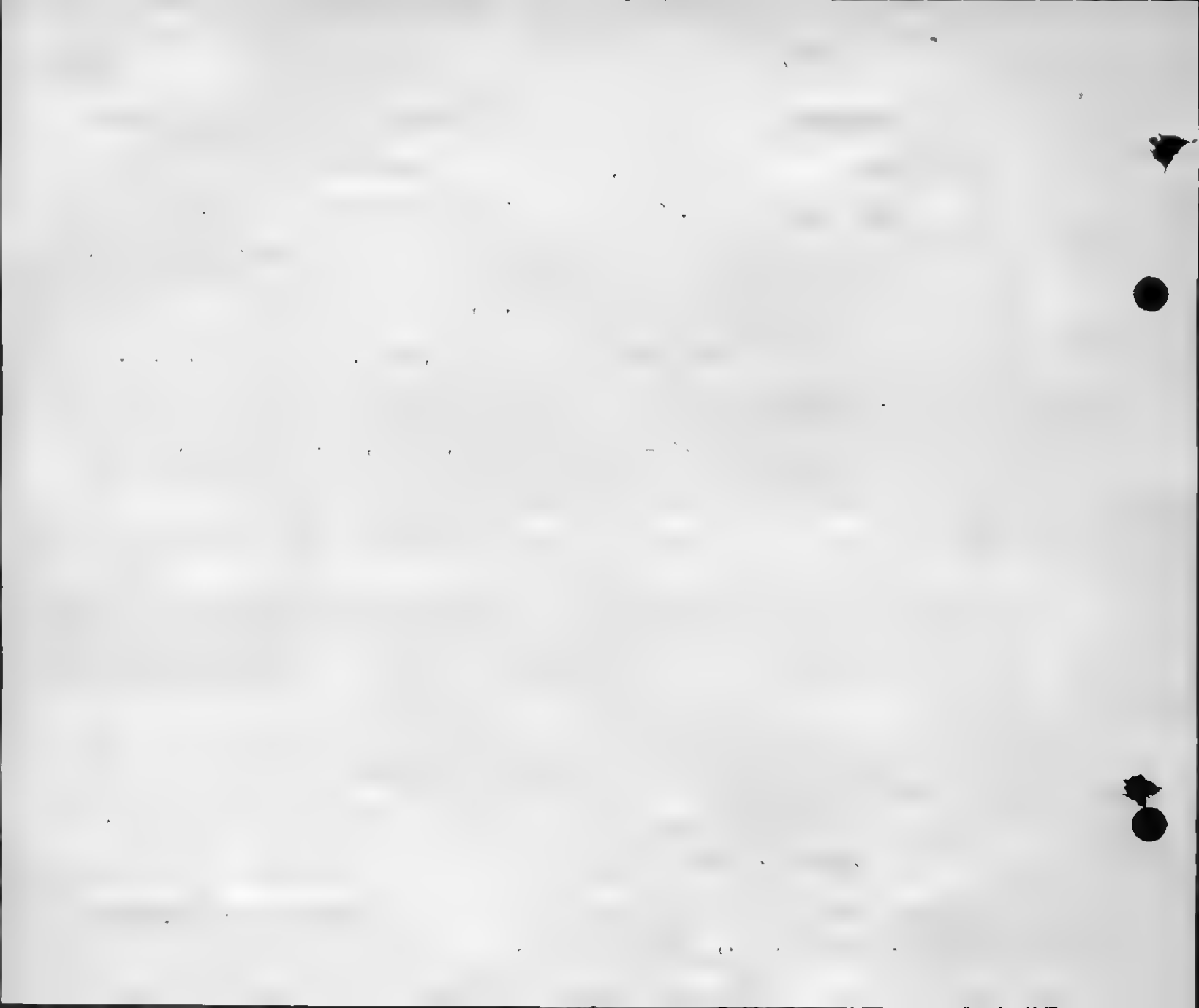
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06953

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>2 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8718 CAMERON STREET apt. 218</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>8718 CAMERON STREET apt. 218</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MILDRED PEABODY LAIRD</b> First Middle Last		4. DATE OF DEATH <b>JUNE 24 1961</b> Month Day Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 8, 1884</b> 9. AGE (in years last birthday) <b>76</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13. FATHER'S NAME <b>GEORGE H. PEABODY</b>		14. MOTHER'S MAIDEN NAME <b>AUGUSTA MUDGE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>013-20-1060 B</b>	
17. INFORMANT <b>Robert P. Laird, West Vancouver, Canada</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive failure of heart</b> DUE TO (b) <b>Multiple, widespread metastatic malignancy</b> DUE TO (c) <b>Unifed mesodermal tumor of uterus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>6-8 weeks</b> <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1960, to June 24, 1961</b> , that (I) <b>(was)</b> last saw the deceased alive on <b>24 June 1961</b> , and that death occurred at <b>1:10 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Ernest E. Harmon</b>		22b. DATE SIGNED <b>JUNE 24, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>ERNEST E. HARMON</b>		22d. ADDRESS <b>9301 Colesville Rd Sil. Spr. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>JUNE 24, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CREMATORY</b>		23d. LOCATION (City, town or county) (State) <b>PRINCE GEORGE'S COUNTY MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Ziska</b>		25a. REC'D BY REGISTRAR <b>JUN 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			



6966

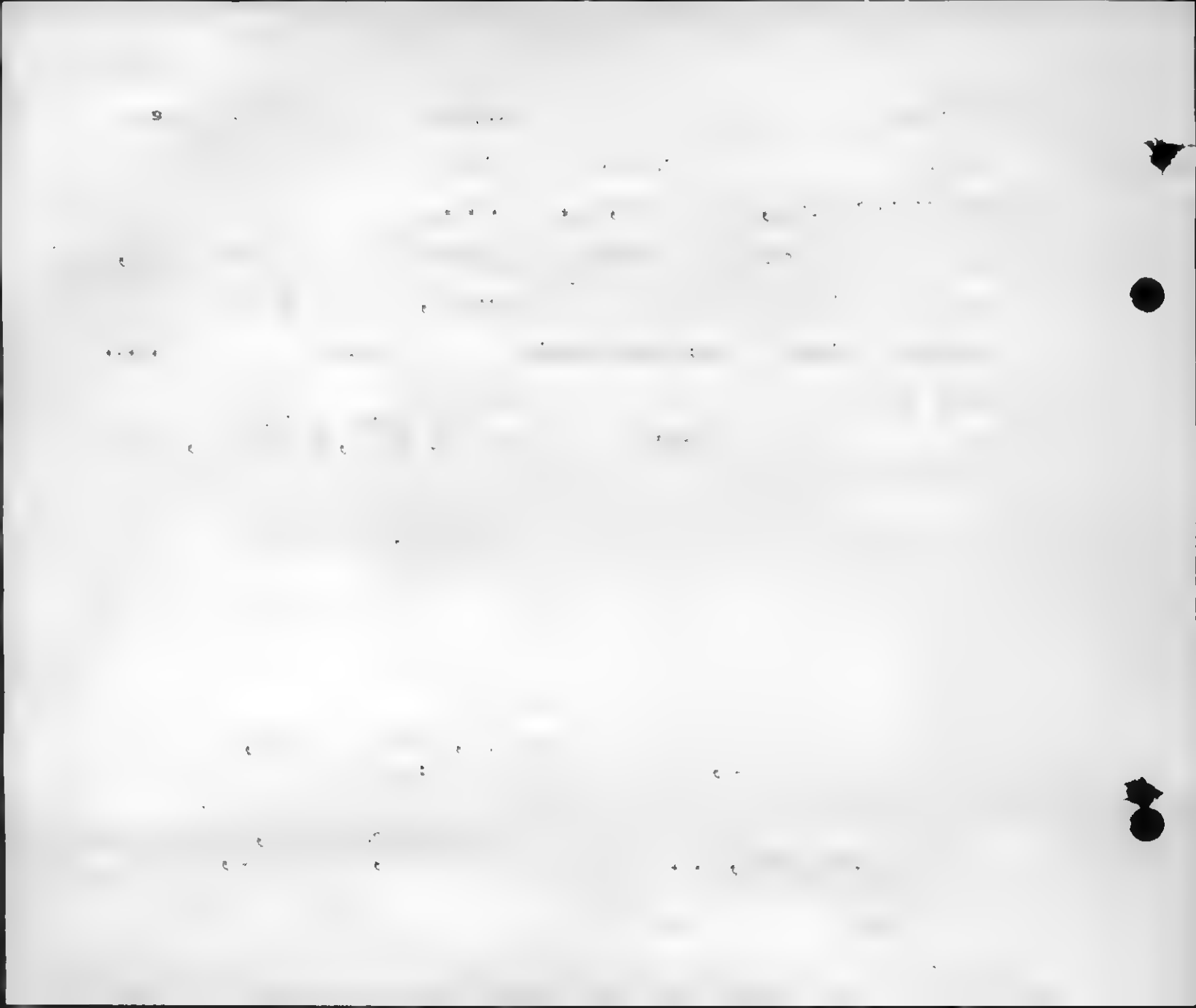
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

06954

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>67 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Lammers</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1896</b>
9. AGE (In years lost birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck body builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck manufacturing</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CIT. ZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Lammers</b>		14. MOTHER'S MAIDEN NAME <b>Annie Otten</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unavailable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Disseminated Carcinoma of</b> DUE TO <b>Unknown primary site</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 mo</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 6, 1961</b> to <b>June 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 12, 1961</b> , and that death occurred <b>3:00AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter Oppelt</i>		22b. DATE SIGNED <b>6-12-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER OPPELT, M.D.</b>		22d. <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial June 15, 1961</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Laurel Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Connelton</i>		25a. REC'D BY REGISTRAR <b>JUN 19 '61</b>	
ADDRESS <b>Laurel, Md</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Finner</i>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

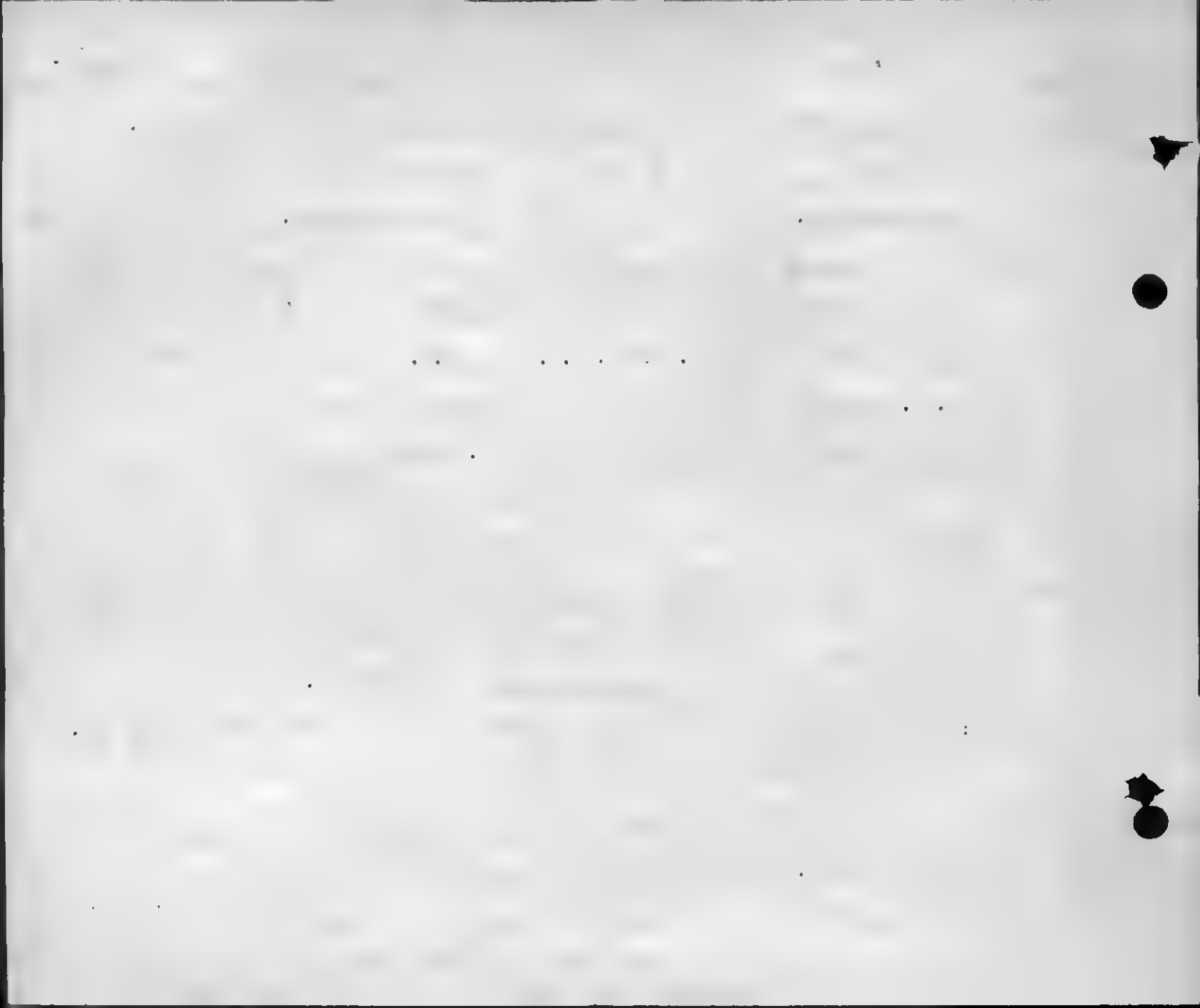
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06955

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in lb <u>11 days</u>		d. STREET ADDRESS <u>9824 Woodland Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Theresa Grace Langbein</u>		4. DATE OF DEATH Month Day Year <u>June 27 19 61</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/2/1874	
9. AGE (In years last birthday) <u>87 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cashier (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. store, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Geo. A. Langbein</u>		14. MOTHER'S MAIDEN NAME <u>Josphine Getz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-05-3579</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> DUE TO (b) <u>Thrombosis, left descending coronary</u> DUE TO (c) <u>Atherosclerosis coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>36 hours</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Fracture rt. hip with malunion 16-18 June '61</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor at home fracturing rt. hip</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:30</u> <u>PM</u> <u>6/16/61</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
20e. (City or town) <u>Silver Spring</u> (County) <u>Montg.</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		22d. LOCATION (City, town, or country) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR <u>H. J. Collins</u>		24a. REC'D BY REGISTRAR <u>30 61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			





TO DEPUTY REGISTRAR, EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department, Baltimore, Maryland, for advice, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 9 60

Items 18821 Film 296  
-27-61 ams  
6968

FOR STATE HEALTH DEPT.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

C6956

1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY IN 1b DOA  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium + Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)  
a. STATE Maryland  
b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington  
d. STREET ADDRESS 1105 Lund Pl

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) David Reed La Roche

4. DATE OF DEATH Month June Day 14 Year 1961

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 10-21-58 9. AGE (In years last birthday) 2 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ronald P. La Roche 14. MOTHER'S MAIDEN NAME Erma Bort

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Address Ronald P. LaRoche-Father-same 2d

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Early Acute interstitial pneumonia  
442x DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) TRACHEA  
DUE TO  
(c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

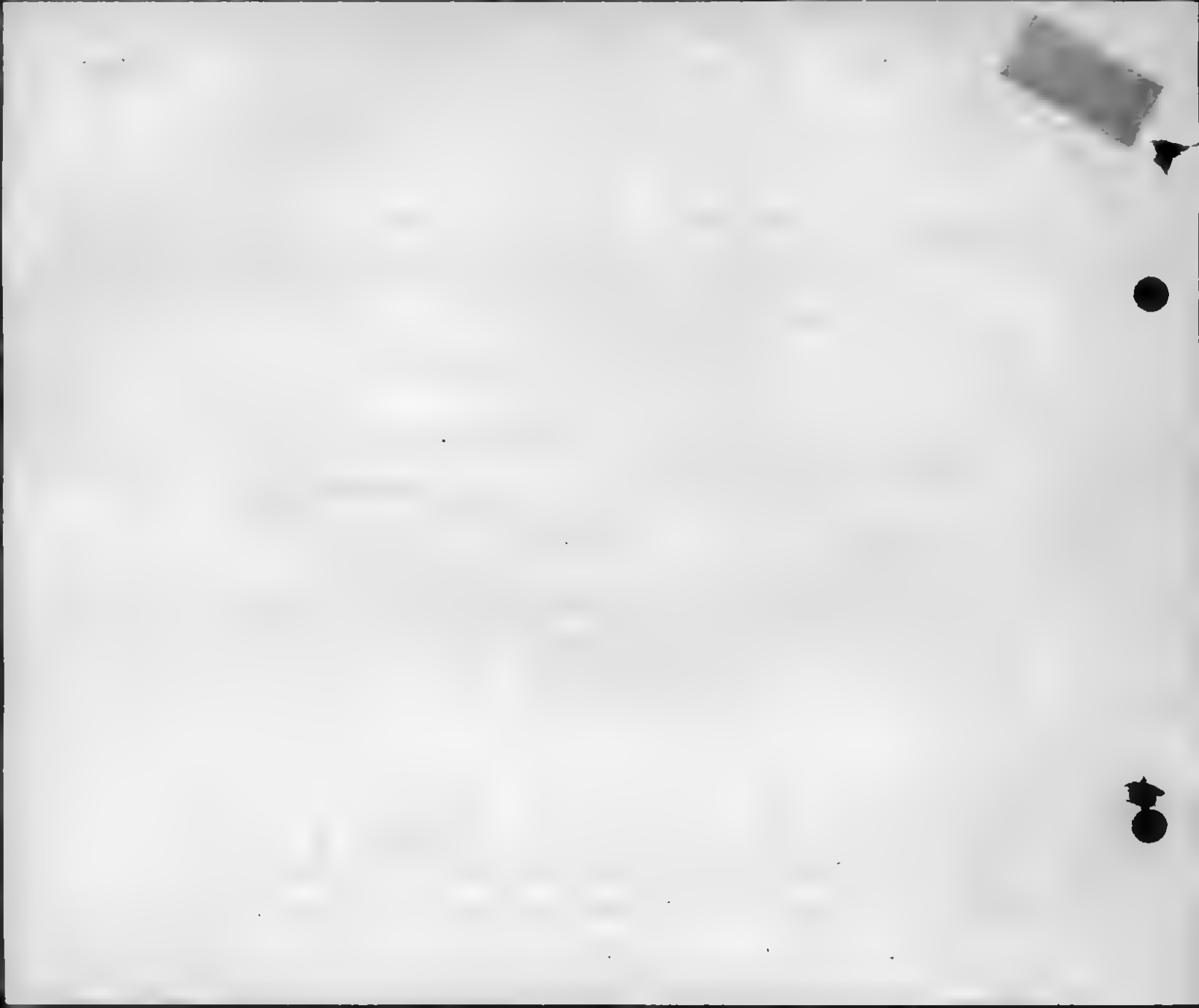
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year. Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 6-14-61

ACTUAL SIGNATURE Frank J. Broschert M.D. NAME (Type) FRANK J. Broschert Address (Street, city, town, or county) (State)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6/16/61 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. 22d. LOCATION (City, town, or country) (State) Arlington, Virginia

23. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Maryland 24a. REC'D BY REGISTRAR JUN 16 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



## CERTIFICATE OF DEATH

Reg. Dist. No. 06957

C969

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Res dence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>20 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SANITARIUM + Hospital</b>		d. STREET ADDRESS <b>714 Bennington Dr.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERTHA Elizabeth LAWSON</b>		4. DATE OF DEATH Month Day Year <b>JUNE 25 1961</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-25-86</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Clarion, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>	
13. FATHER'S NAME <b>Clarence Myers</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jane Snyder</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>no.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>175-059444</b> Copied from chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>thrombosed atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1961</b> to <b>June 25, 1961</b> , that I last saw the deceased alive on <b>June 25, 1961</b> , and that death occurred at <b>4:20 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Abraham W D Anish</b>		ADDRESS (Street, city or town, state) <b>927 Rushing Dr Silver Spring Md</b>	
PHYSICIAN'S NAME (Type) <b>ABRAHAM W D ANISH</b>		DATE SIGNED <b>6-25-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-28-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		22d. LOCATION (City, town, or county) (State) <b>WILKINSBURG, PENNA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas J. Collins</b> ADDRESS <b>3821-14th ST. N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 28 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be retained by the hospital or attending physician. Page 2 is to be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

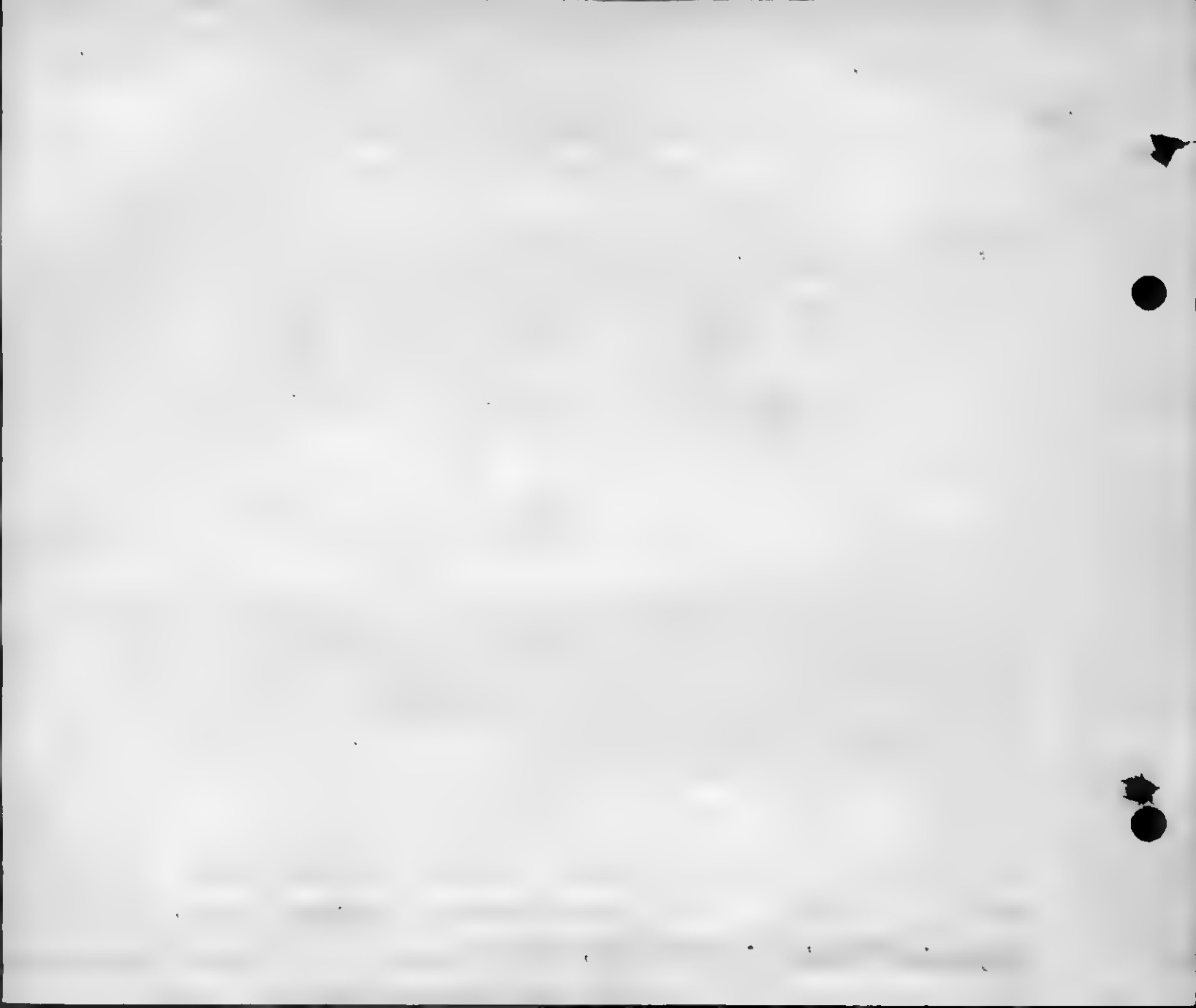
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

0970

06958

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home, 3100 Jennings Rd.</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>3100 Jennings Rd.</u>						
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Antonio</u> Middle <u>NMI</u> Last <u>Lopes</u>			<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>27</u> Year <u>1961</u>						
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
<b>8. DATE OF BIRTH</b> <u>April 1, 1880</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days Hours Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Merchant</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months	Days Hours Min.								
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Italy</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Italy</u>		<b>13. FATHER'S NAME</b> <u>Salvatore Lopes</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>Antoinette Samperi's</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>579-28-4261</u>					
<b>17. INFORMANT</b> <u>Joseph Lopes</u>		<b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Myeloma</u> DUE TO (c)		<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 day</u> <u>6 months</u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Old Fracture, left hip</u>									
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 5, 1960</u> <b>to</b> <u>June 27, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>June 24, 1961</u> , <b>and that death occurred at</b> <u>10 P.M.</u> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>John C. K. Yu</u>		<b>22b. DATE SIGNED</b> <u>June 27, 61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>John C. K. Yu</u>					
<b>22d. ADDRESS</b> <u>4912 Adrian St., Rockville, Md.</u>		<b>22e. ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>7/1/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gate of Heaven Cemetery</u>					
<b>23d. LOCATION (City, town or county)</b> <u>Montgomery County, Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Humphrey, Inc.</u>							
<b>25a. REC'D BY REGISTRAR</b> <u>DATE JUL 5 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Carroll S. Thomas</u>							



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8971

08214

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>1b</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyle</u> d. STREET ADDRESS <u>Route #2 Box 705</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>BABY GIRL "A" LYLES</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>3</u> Year <u>1941</u>		<b>9. AGE</b> (In years last birthday) <u>7</u> yrs. <u>850</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Montgomery Co. Md.</u>			
<b>13. FATHER'S NAME</b> <u>Alfred Dome</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Mae Lyles</u>		<b>17. INFORMANT</b> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. DUE TO (c) }						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that</b> <u>1</u> (this hospital) attended the deceased from <u>June 2</u> , 19 <u>41</u> , to <u>June 3</u> , 19 <u>41</u> , that (I) (we) last saw the deceased alive on <u>June 2</u> , 19 <u>41</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.		<b>22b. DATE SIGNED</b>	
<b>22a. SIGNATURE</b> <u>M. H. Grosvenor</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>MABEL H. GROSVENOR, M.D.</u>		<b>22d. ADDRESS</b> <u>2203 WYOMING, N.W., WASH., D.C.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. A. ...</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>CREMATION</u>		<b>23b. DATE THEREOF</b> <u>7-4-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SUBURBAN HOSPITAL</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>OLD GEORGETOWN RD. BETHESDA, MARYLAND</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>AMELIA CARTER - ADM. - SUBURBAN HOSPITAL</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JUL 13 61</u>		<b>25c. REGISTRAR'S SIGNATURE</b>		<b>25d. REGISTRAR'S SIGNATURE</b>	

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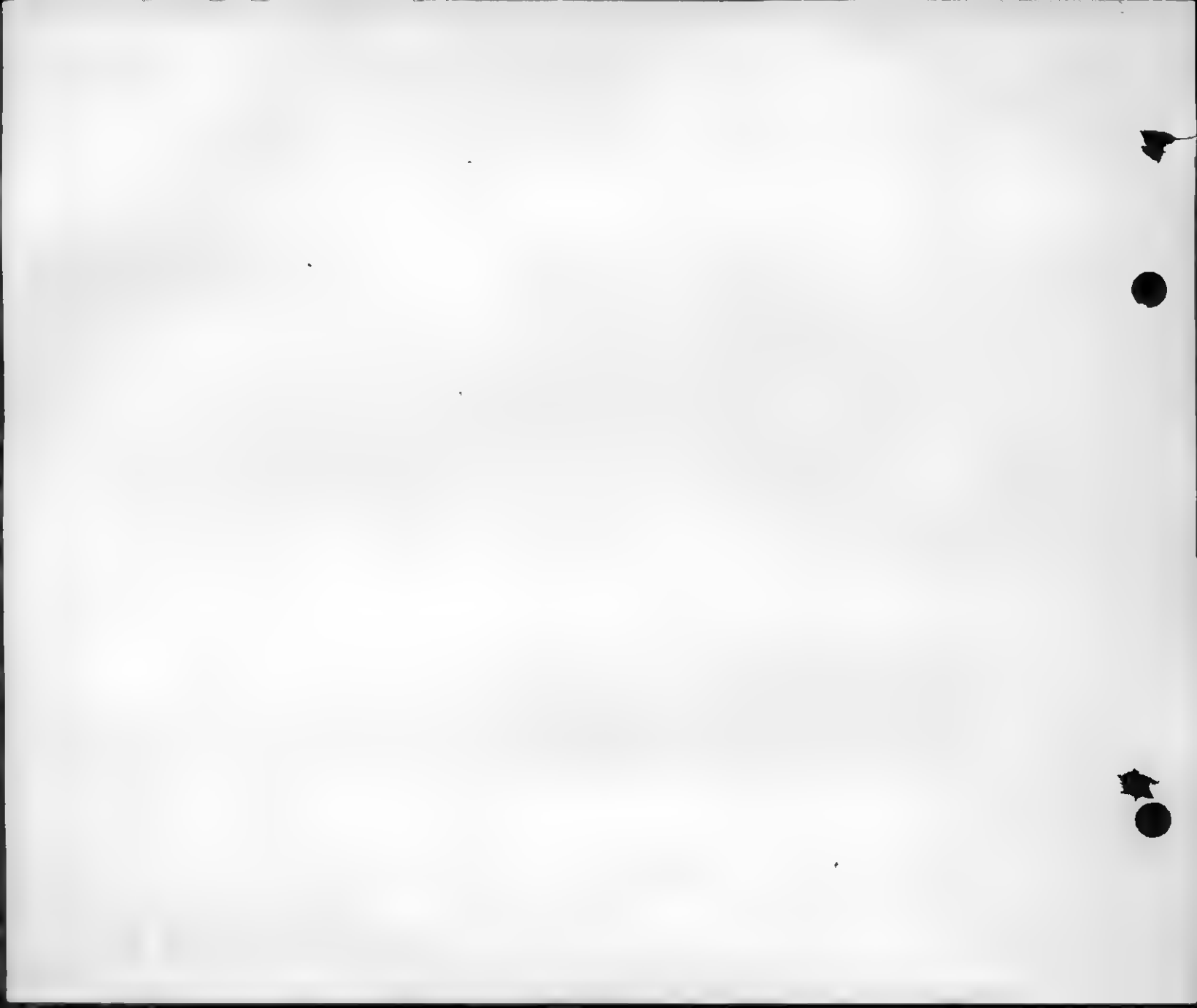
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>Route #2 Box 305 1</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl "B" Hyles</u>		4. DATE OF DEATH <u>June 3 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C.</u>	7. MARried <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-61</u>
9. AGE (In years last birthday) <u>— yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. <u>8 0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alfred Dome</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Mae Sykes</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 2 1961</u> to <u>June 3 1961</u> , that (I) (we) last saw the deceased alive on <u>June 2 1961</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>M. Grosvenor</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M. GROSVENOR, M.D.</u>		22d. ADDRESS <u>2203 WYOMING, N.W., WASH., D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>7-4-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>	23d. LOCATION (City, town, or county) (State) <u>OLD GEORGETOWN ROAD, BETHESDA, MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Amelia Barker - Adm. - (per 915)</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u>	
ADDRESS <u>SUBURBAN HOSPITAL, BETHESDA, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Puma</u>	

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate be executed in 24 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6973

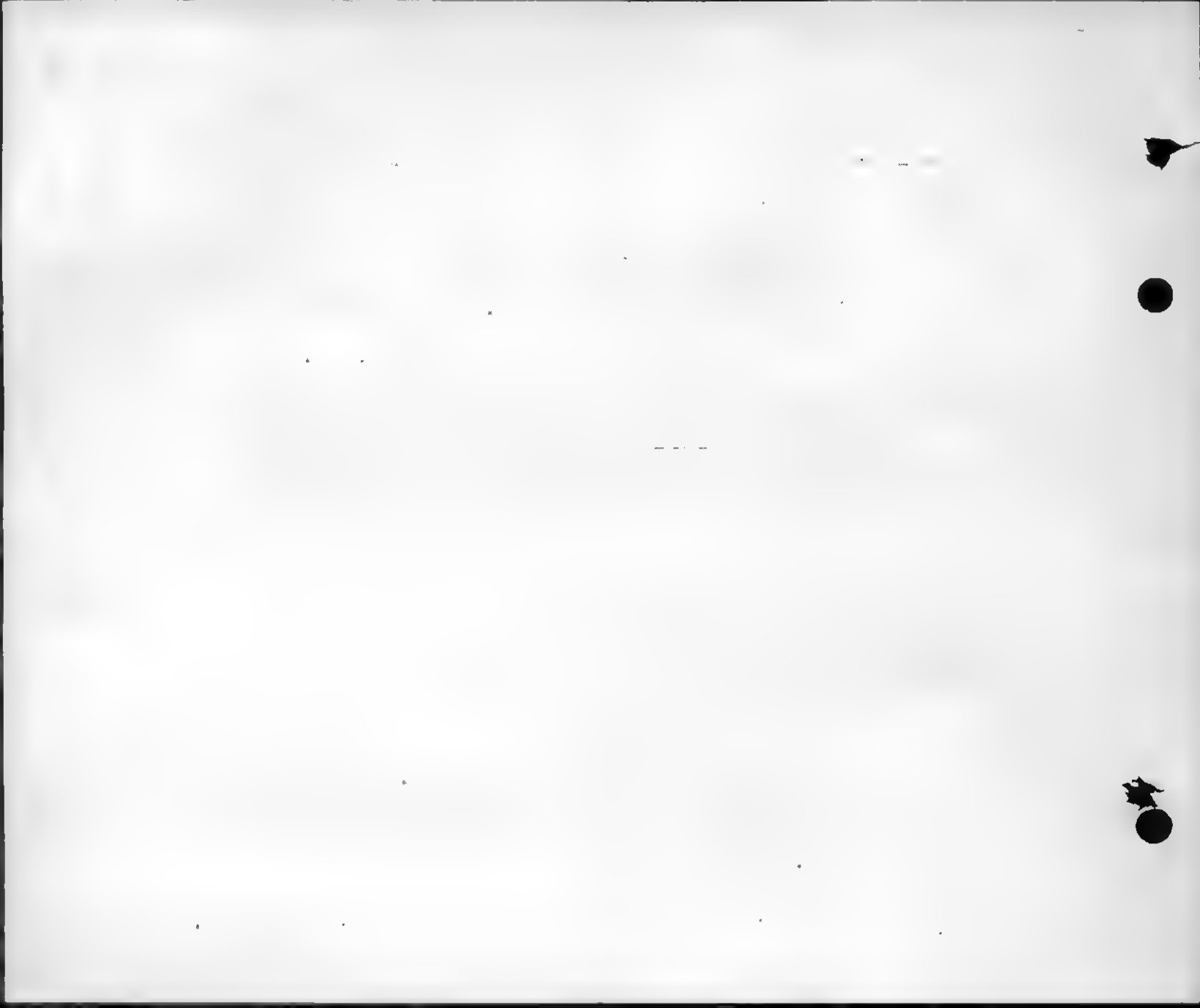
## CERTIFICATE OF DEATH

Reg. Dist. No. C6959

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Lewisdale</b>				c. LENGTH OF STAY IN lb <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD # 1, Monrovia</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>--</b> Last <b>Lyles</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 12, 1895</b>	
9. AGE (In years last birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Lewisdale, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Vatchel Lyles</b>				14. MOTHER'S MAIDEN NAME <b>Clarsia Zigler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW 1</b>				16. SOCIAL SECURITY NO. <b>-----</b>			
INFORMANT <b>Mrs Edna Lyles, Item 2</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of prostate with glandular metastases</b> <b>177X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>a. m.</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/14</b> to <b>6/12</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>6/11</b> , 19 <b>61</b> , and that death occurred at <b>4 A. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James P. Kerr</b>				ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>			
PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>				DATE SIGNED <b>6/12/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 15, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Purdum, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. McPherson</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 14 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

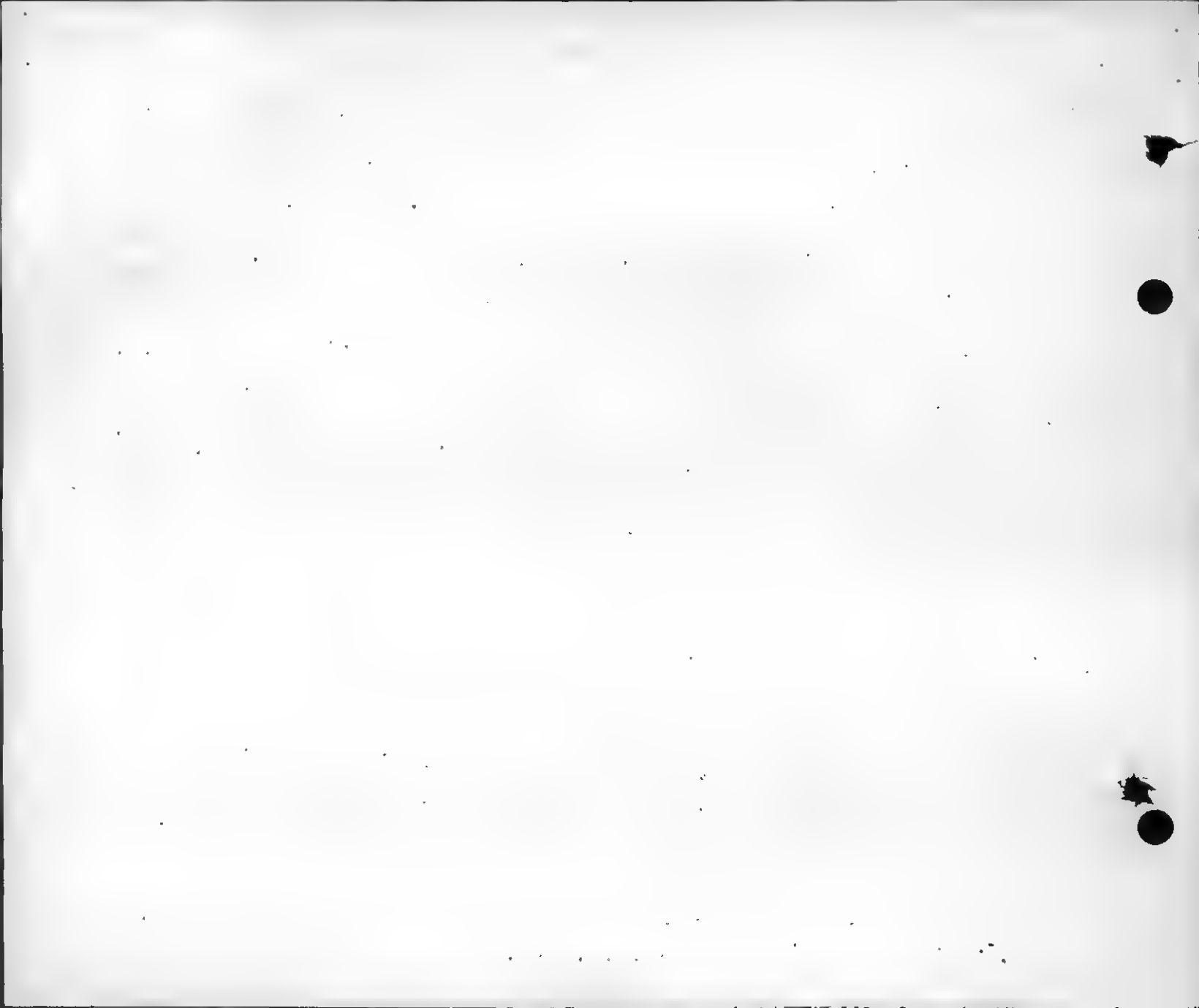
may be retained in hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



C6960

## Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN TB <u>52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Christine A. Lynch</u>		4. DATE OF DEATH Month Day Year <u>June 11 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-07</u>
9. AGE (In years last birthday) <u>53</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. <u>53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Christina Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>3503</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary Artery Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e. (City or town) <u>Washington, D. C.</u>		(County) (State)	
21. I certify that I attended the deceased from <u>6-11</u> , 19 <u>61</u> , to <u>6-11</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6-11</u> , 19 <u>61</u> , and that death occurred at <u>6:00</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Bailey</u>		DATE SIGNED <u>June 14 1961</u>	
PHYSICIAN'S NAME (Type) <u>James A. Bailey</u>		M.D. <u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-14-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clivett Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Collins</u>		24a. REC'D BY REGISTRAR <u>June 14 1961</u>	
24b. REGISTRAR'S SIGNATURE <u>James J. Collins</u>		24c. ADDRESS <u>1-1411st St. N.W. Wash. D.C.</u>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

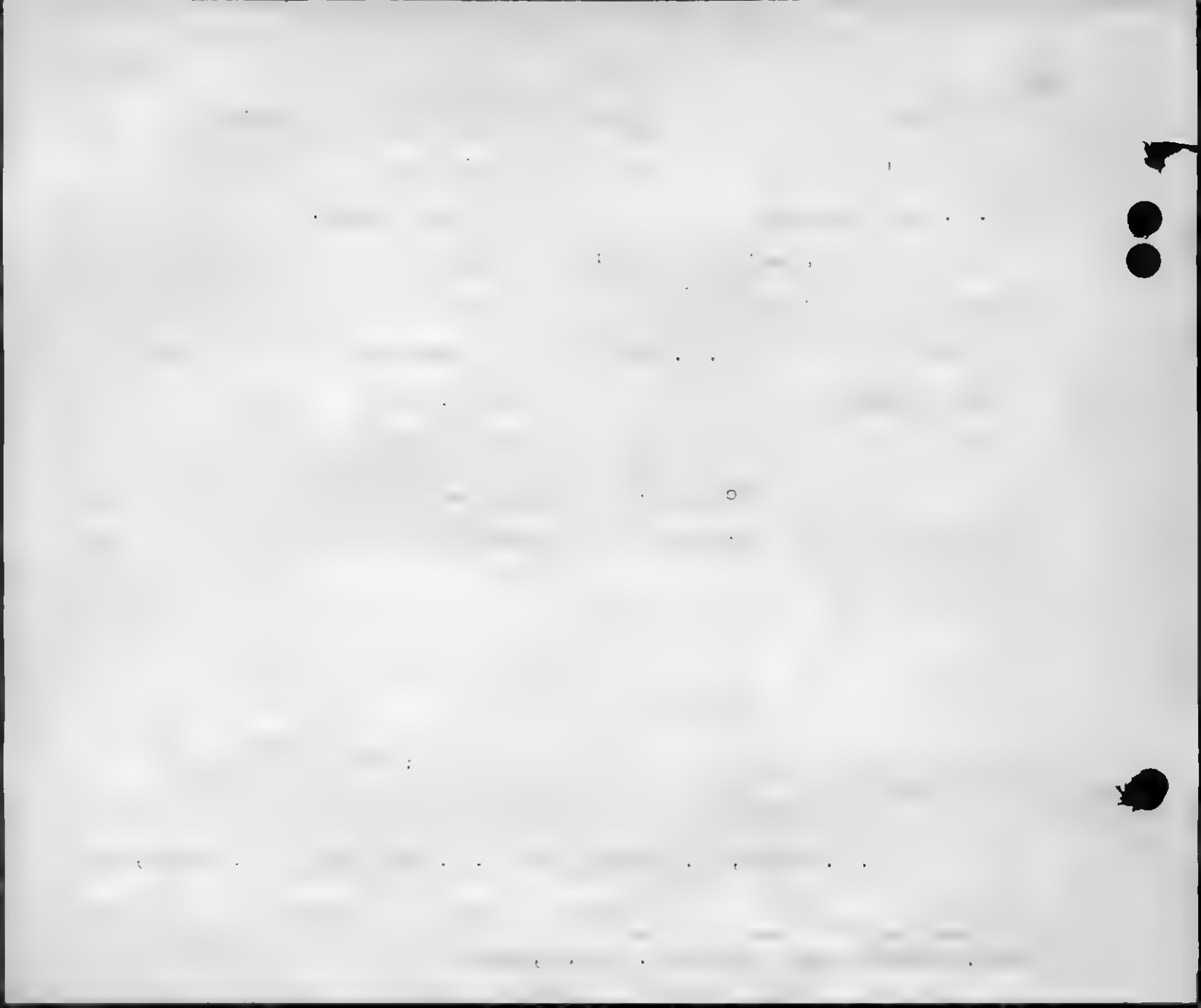
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15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

6975

06961

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>1044 26th Road S.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Joseph Bertram LYNCH</b> First Middle Last <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>Caucasian</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DIVORCED</b> <input type="checkbox"/> <b>9. AGE</b> (in years last birthday) <b>68 yrs.</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Officer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U. S. Navy</b> <b>11. BIRTHPLACE</b> (Country & State or foreign country) <b>Massachusetts</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>June 27 19 61</b> <b>13. FATHER'S NAME</b> <b>Edward LYNCH</b> <b>14. MOTHER'S M.A.DEN NAME</b> <b>Mary E. CARTY</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Hospital Records</b> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, right cerebral hemisphere</b> DUE TO (b) <b>Atherosclerosis, generalized</b> DUE TO (c) <b>331X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>Years</b>	
<b>20a. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20d. (City or town)</b> (County) (State) <b>June 26 1961 to June 27 1961</b> <b>21. I certify that</b> <b>10</b> (in hospital) <b>attended the deceased from</b> <b>June 26 1961</b> <b>to</b> <b>June 27 1961</b> , <b>that</b> <b>we</b> last saw the deceased alive on <b>June 27 1961</b> , <b>and that death occurred at</b> <b>2:40PM</b> , <b>from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>G. I. WALKER, JR., CAPT, MC, USN</b>		<b>22b. DATE SIGNED</b> <b>6-28-61</b> <b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>6-30-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington Virginia</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>JOS. GAWLERS &amp; SONS, 1756 Penna. Ave., NW, WashDC</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JUN 30 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Howard</b>	





TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. If the funeral director, the attending physician and complete page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

6978 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06962

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>19 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Kearneysville</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 x 3</b> d. STREET ADDRESS <b>R.F.D. # 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Caroline</b> Middle <b>Thelma</b> Last <b>Macoughtry</b>		4. DATE Month <b>June</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 5, 1908</b>
9. AGE (In years last birthday) <b>52</b>		10. IF UNDER 1 YEAR Months <b>52</b> Days <b>11</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William J. Heaton</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Tagg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Breast</b> DUE TO <b>17 0x</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last: (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 23</b> 19 <b>61</b> to <b>June 11</b> 19 <b>61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 11</b> 19 <b>61</b> , and that death occurred at <b>4:10PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin A. Borowsky</b>		22b. DATE <b>6/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>BENJAMIN A. BOROWSKY, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Trans 6/12/61</b>		23b. DATE THEREOF <b>6/12/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Episcopal Cemetery</b>		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		DATE <b>JUN 13 '61</b>	

22b. DATE  
**6/12/61**

22d. ADDRESS  
**The Clinical Center, National Institutes of Health, Bethesda 14, Md.**

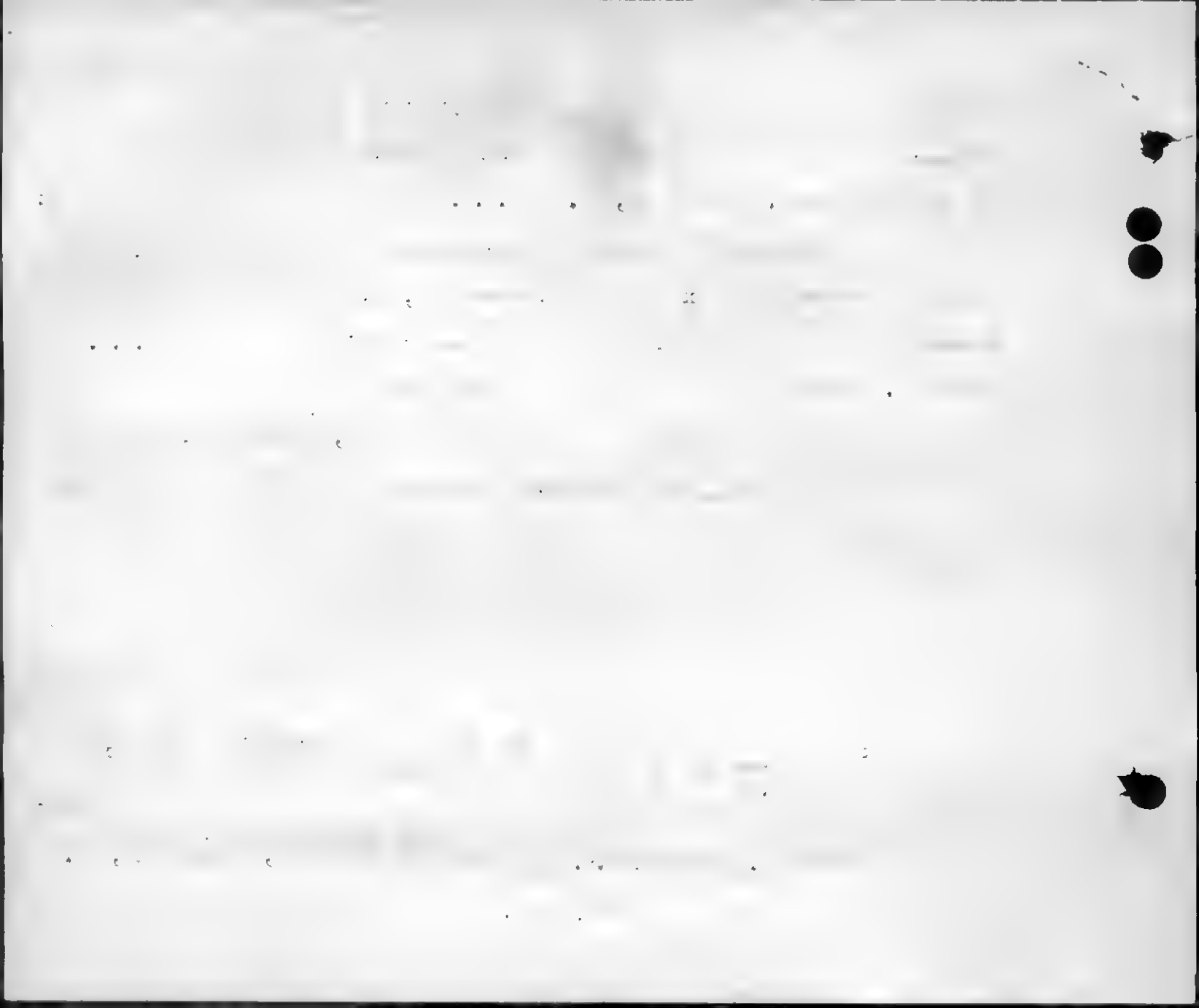
23b. DATE THEREOF  
**6/12/61**

23d. LOCATION (City, town, or county) \_\_\_\_\_ (State) \_\_\_\_\_

25a. REC'D BY REGISTRAR  
**Bethesda, Maryland**

25b. REGISTRAR'S SIGNATURE  
**Arthur S. Kline**

DATE **JUN 13 '61**



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. The death certificate may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

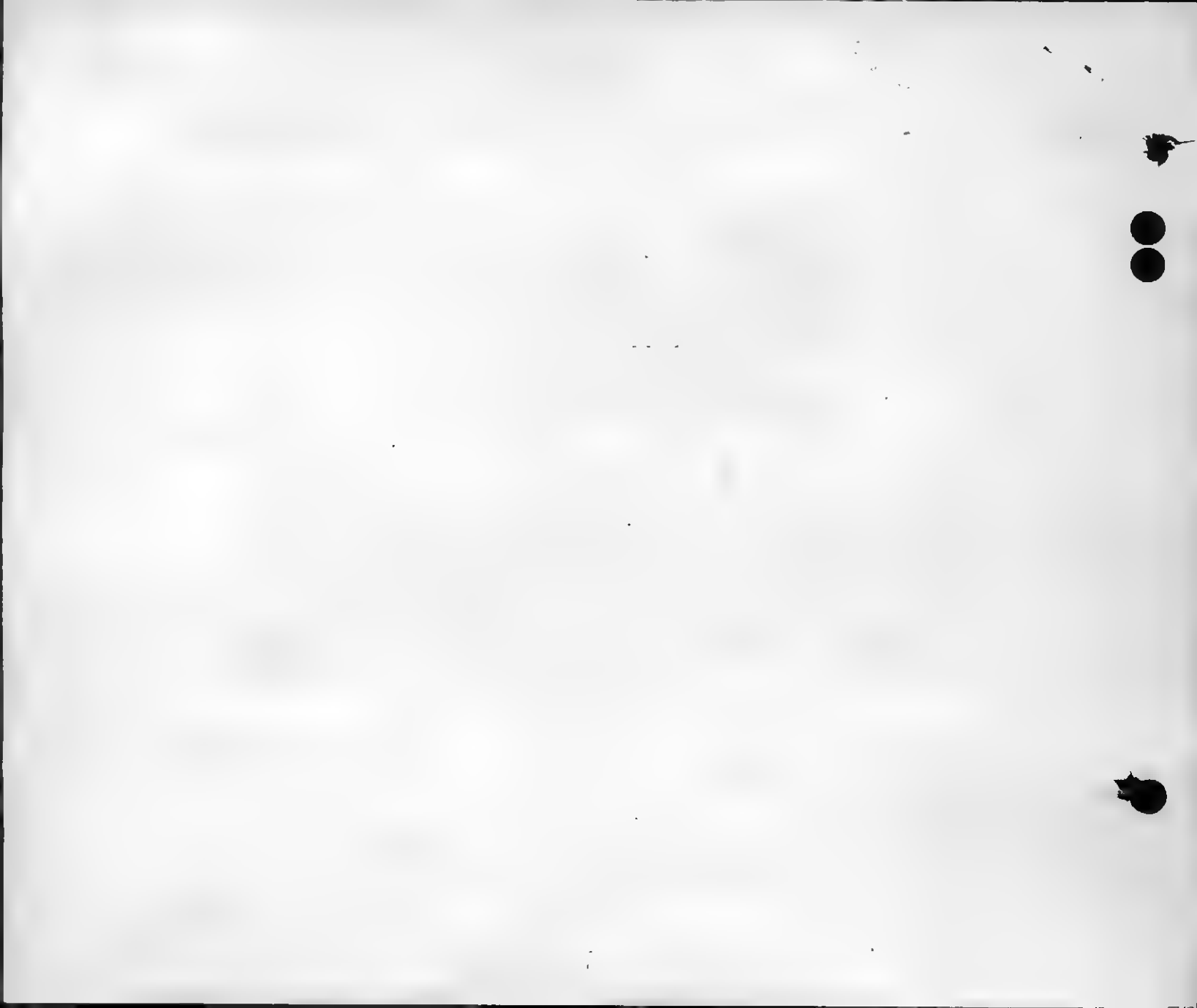
VR AT5 (4)  
ISM 9/59

6977

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

06963

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived - If institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>				d. STREET ADDRESS <b>110701 MacArthur Boulevard</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>M.</b> Last <b>Marsden</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/1886</b>	9. AGE (In years last birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Theodore Hill</b>				14. MOTHER'S MAIDEN NAME <b>Emsey Henderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>4820 Chevy Chase Drive</b> <b>(S) Robert B. Marsden, Chevy Chase, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422-1 Central Cardiovascular Disease</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 19 1961</b> to <b>June 28 1961</b> , that (I) (we) lost saw the deceased alive on <b>27 June 1961</b> , and that death occurred <b>12 25</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>W. F. Cresswell, Jr.</b>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. F. Cresswell, Jr.</b>				22d. ADDRESS <b>2029 Que St. NW, Wash. D. C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/1/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Church Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Potomac, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 6 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



TO HOSPITAL OR AFTER BURIAL: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

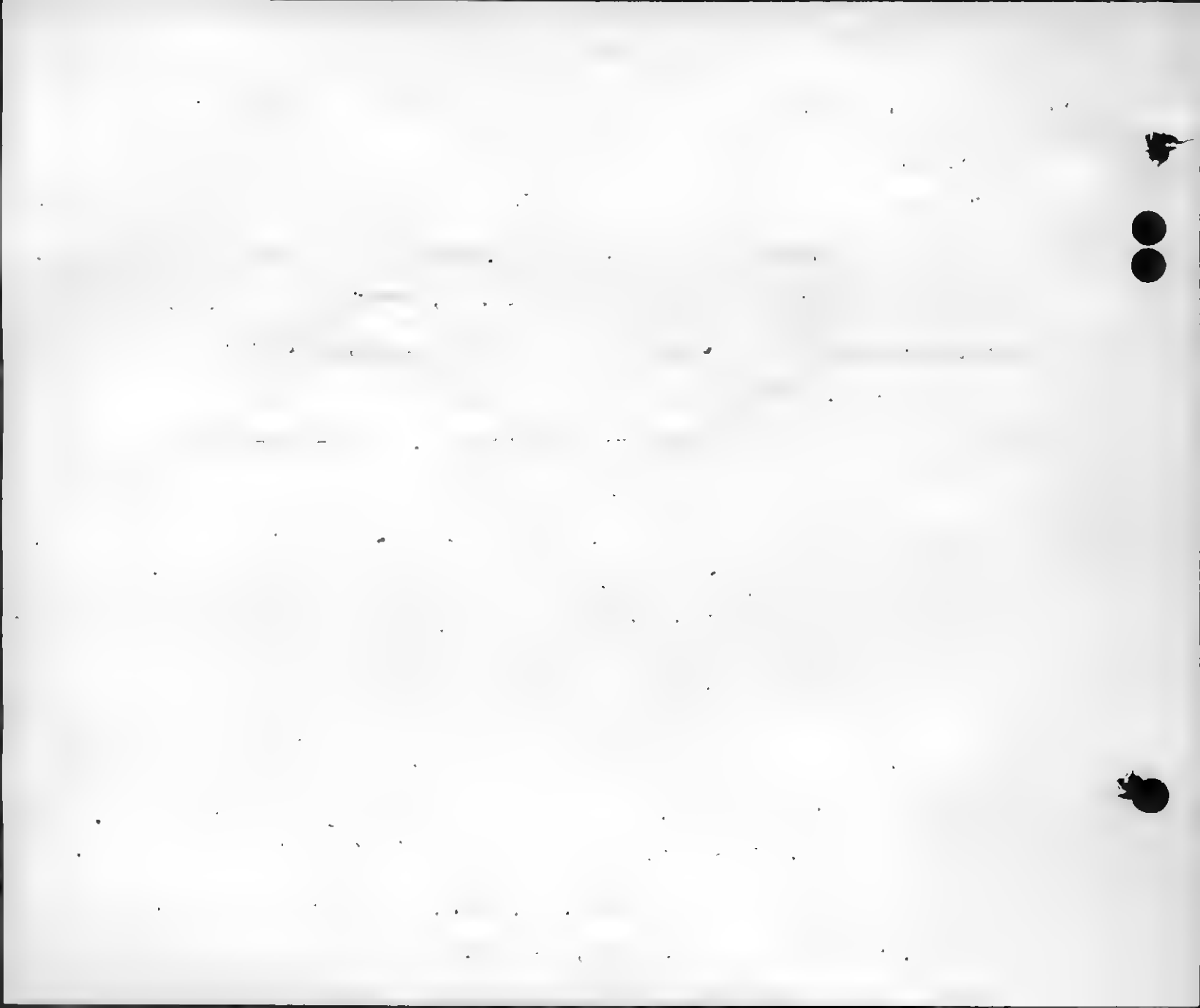
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6978

## CERTIFICATE OF DEATH

Reg. Dist. No. 06964

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c LENGTH OF STAY IN 1b <b>Rockville</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>838 Rockville Pike</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Wilbert</b> Middle <b>A</b> Last <b>MARTH</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>19 61</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1909</b>
9. AGE (In years last birthday) <b>52</b> yrs		IF UNDER 1 YEAR Months <b>3</b> Days <b>13</b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Radio repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Radio</b>	11. BIRTHPLACE (State or foreign country) <b>Germantown, Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William G. Marth</b>	
14. MOTHER'S MAIDEN NAME <b>Ada Carter</b>		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>Unknown-yes</b>		INFORMANT Address <b>Gertrude M. Marth-wife-same Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> 44-3 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular hypertensive disease</b> DUE TO (c) <b>Cirrhosis of liver, with jaundice &amp; ascites - 1 year.</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus - 5 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 years</b>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 8, 1960</b> to <b>June 8, 1961</b> , that I last saw the deceased alive on <b>June 7, 1961</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. Linticum</b> M.D.		ADDRESS (Street, city or town, state) <b>1105 Washington St. Rockville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. H. Linticum</b>		DATE SIGNED <b>June 8, 1961</b>	
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/10/1961</b>	22c NAME OF CEMETERY OR CREMATORY <b>Rockville Cem. Assn.</b>	22d LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6979

66965

**1. PLACE OF DEATH**

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

Since 6/16/61

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution; Residence before admission)

a. STATE

District of Columbia

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

2733 Ordway Street, N. W. Apt. 6

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED**  
(Type or print)

Norma

f. First

L.

MASON

Last

**4. DATE OF DEATH**

Month

Day

Year

June

10

19 61

**5. SEX**

Female

**6. COLOR OR RACE**

White

**7. MARRIED** ☐ NEVER MARRIED ☒ **8. DATE OF BIRTH**

WIDOWED ☐ DIVORCED ☐

May 9, 1915

**9. AGE** (In years, last birthday)

46 yrs.

**10. IF UNDER 1 YEAR**

Months 1 Days 1

**11. IF UNDER 24 HRS.**

Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

Secretary

**10b. KIND OF BUSINESS OR INDUSTRY**

U. S. Government

**11. BIRTHPLACE** (County & State, or foreign country)

Minnesota

**12. CITIZEN OF WHAT COUNTRY?**

USA

**13. FATHER'S NAME**

Unknown

**14. MOTHER'S MAIDEN NAME**

Unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give year or dates of service)

No

**16. SOCIAL SECURITY NO.**

None

**17. INFORMANT**

Mrs. W. A. Sterba-Friend Bethesda, Maryland

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

**PART I. DEATH WAS CAUSED BY:**  
**IMMEDIATE CAUSE (a)**

Myocardial decompensation,

170 X  
Conditions, if a, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO

(b) Advanced Inanition, Dehydration,

DUE TO

(c) Carcinomatosis, (Breast)

**INTERVAL BETWEEN ONSET AND DEATH**

24 Hrs.

1 Mo.

6 Yrs.

**PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)**

Peripheral Circulatory Failure

**20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY**

Month, Day, Year

**20d. INJURY OCCURRED**

While at work ☐ Not While at work ☐

**20a. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f. (City or town)**

**(County)**

**(State)**

**21. I certify that (I) (this hospital) attended the deceased from**

1957

to

6-10

1961

that (I) (we) last saw the deceased alive on

6-9-1961

and that death occurred at

6:30 AM

from the causes and on the date stated above.

**22a. SIGNATURE**

**22c. PHYSICIAN'S NAME** (Type)

James W. Long, M.D.

**ATTENDING PHYS**

**MED. DIRECTOR**

**STAFF PHYS.**

**22b. DATE SIGNED**

6-10-61

**22d. ADDRESS**

6601 Greentree Road, Bethesda, Maryland

**23a. BURIAL, CREMATION REMOVAL** (Specify)

**23b. DATE THEREOF**

Bur-transit

6-10-61

**23c. NAME OF CEMETERY OR CREMATORY**

Hebbing Park Cemetery

**23d. LOCATION** (City, town or county)

St. Louis County, Minn.

**24. FUNERAL DIRECTOR'S SIGNATURE**

Robert A. Pumphrey

**ADDRESS**

Bethesda, Maryland

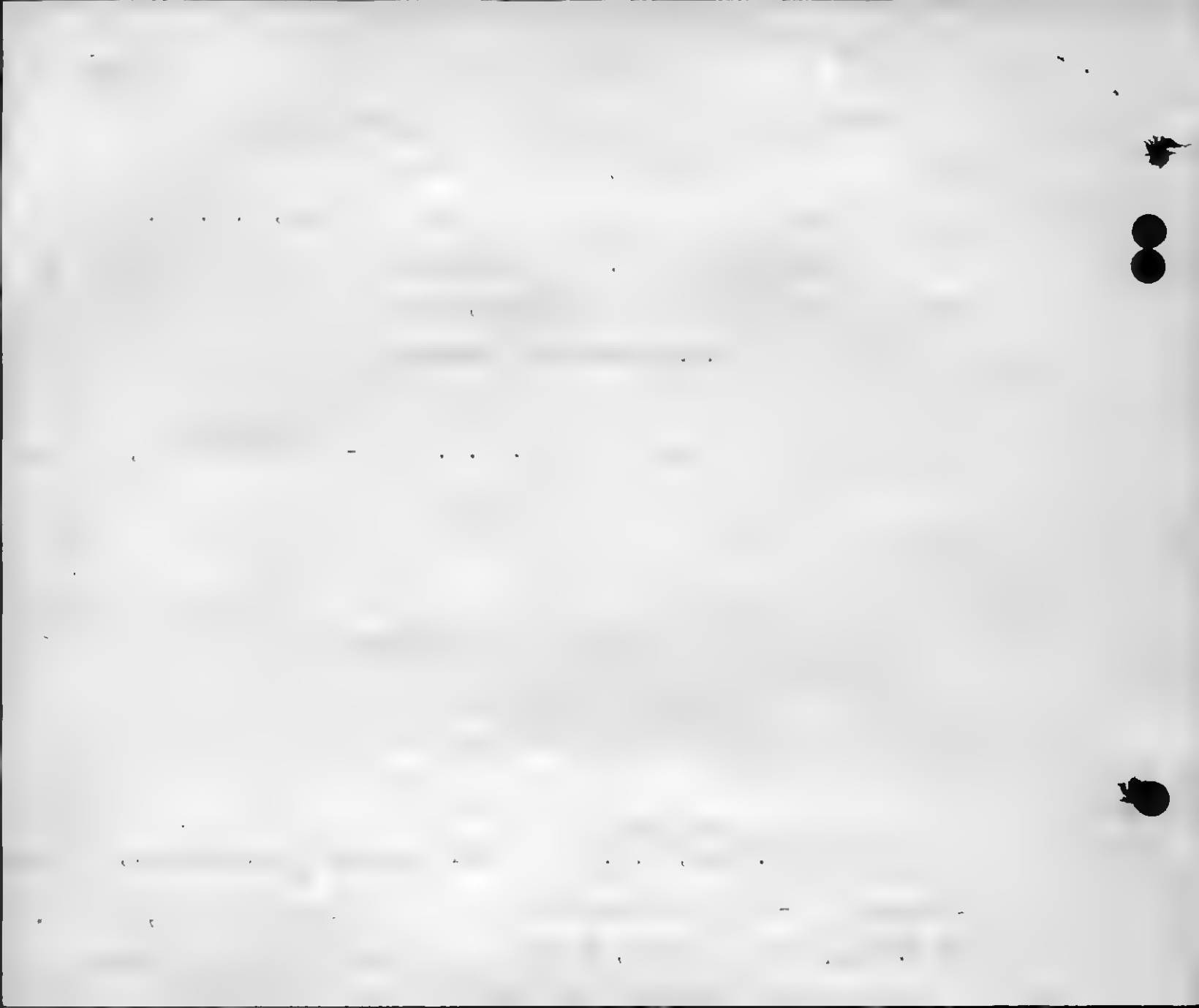
**25a. REC'D BY REGISTRAR**

JUN 13 '61

**25b. REGISTRAR'S SIGNATURE**

Arthur L. Kline

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



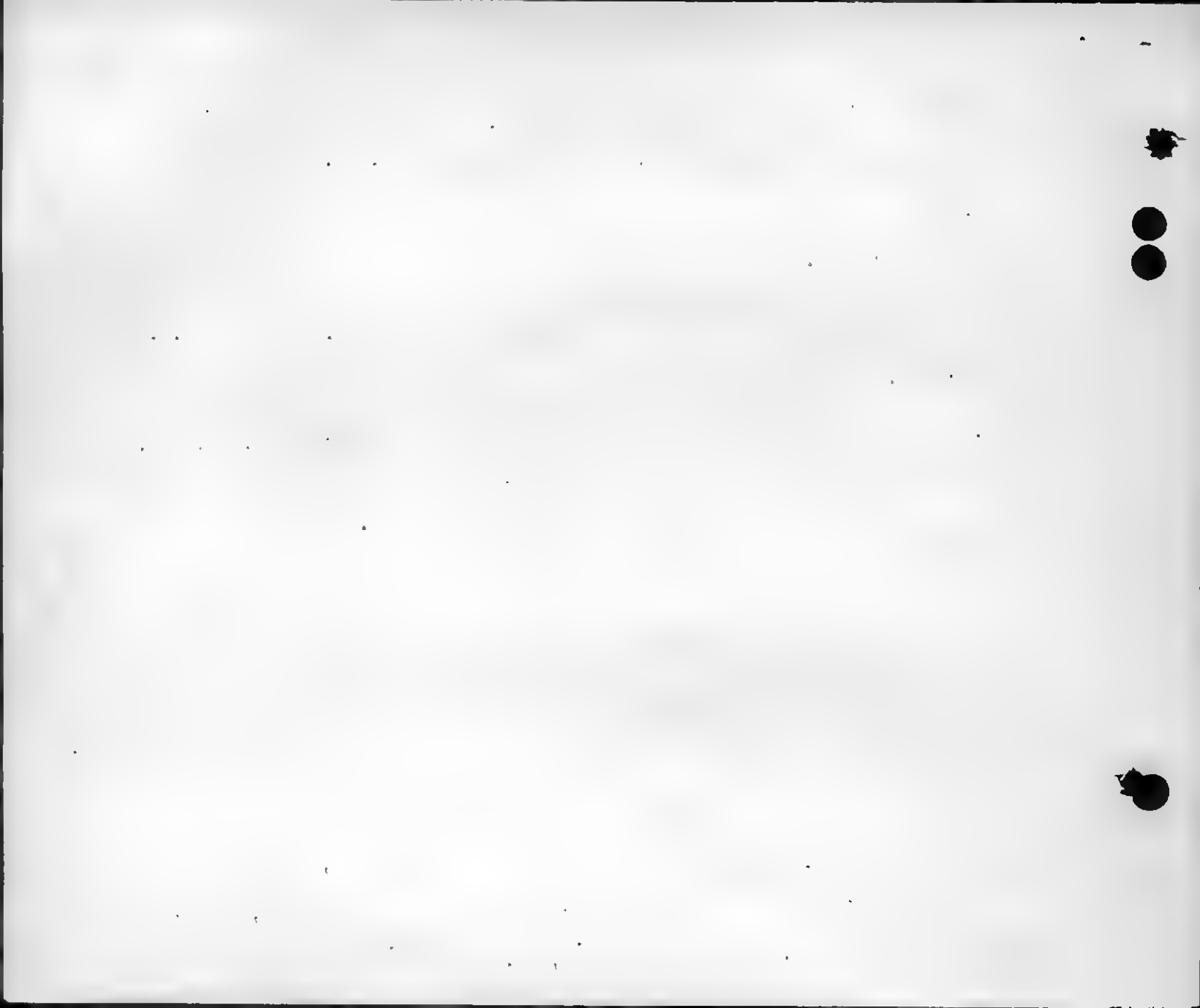


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

6980

06966

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, Rt. 3 Maryland X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Grace M. McCrossin</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/12/78</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hwf</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Darnestown, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Edward S. Hunter</u>		14. MOTHER'S MAIDEN NAME <u>Anna Virginia Hunter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Bertha Myers Gaithersburg, Rt. 3 Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>CEREBRAL THROMBOSIS WITH HEMIPLEGIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 wk</u> <u>2 yr.</u> <u>2 wk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1952</u> to <u>JUNE 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>JUNE 17 1961</u> , and that death occurred at <u>3:33 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Leo M. Curtis</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>		22d. ADDRESS <u>8218 Wisconsin Avenue Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/ 20/ 61</u>	<u>Rockville Cemetery</u>	<u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 20 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6981

06967

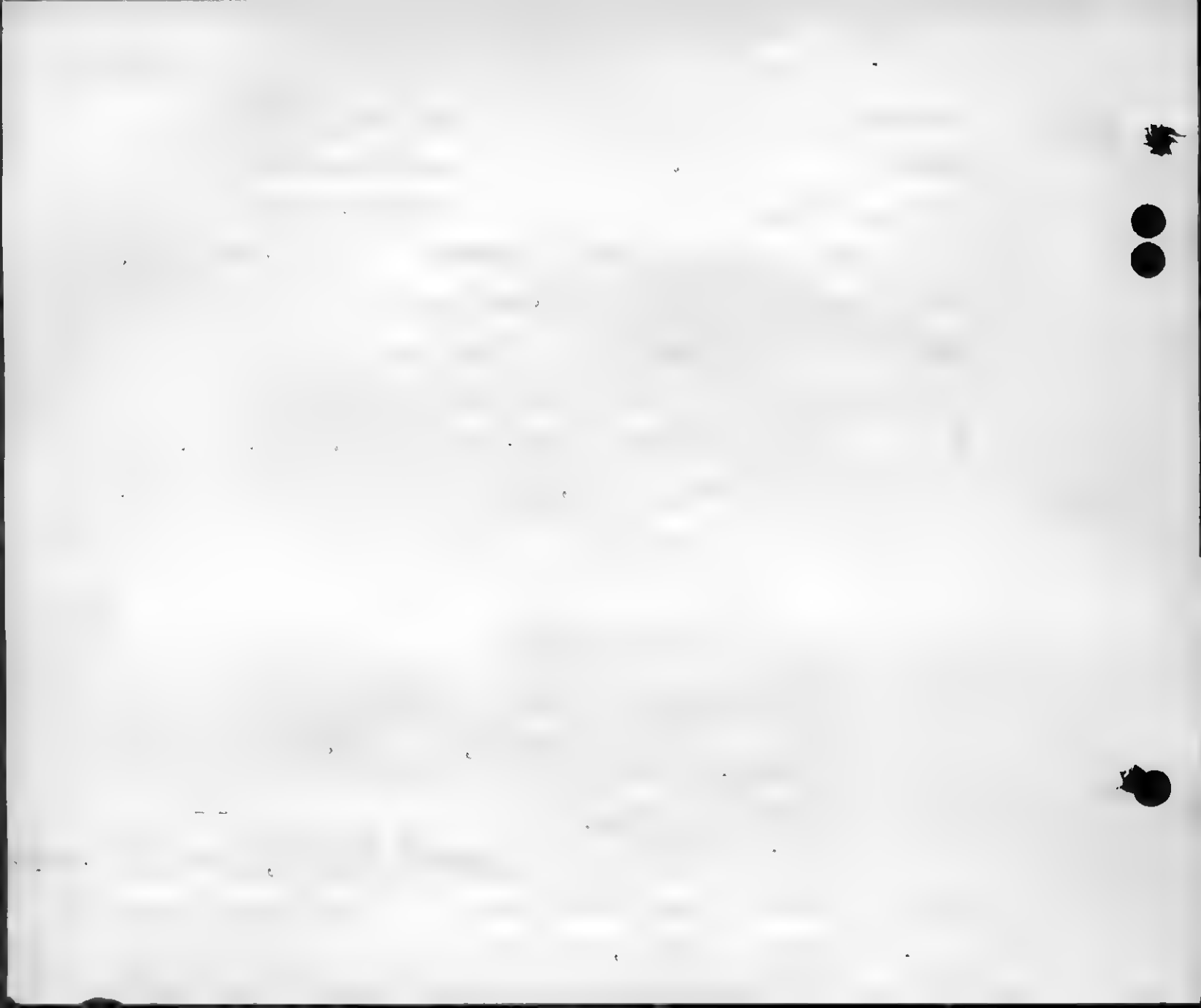
1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>24 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence, before admission) a. STATE <b>New York</b> b. COUNTY <b>Long Island, Freeport</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Elliott Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Cora</b> First <b>Helen</b> Middle <b>McDermott</b> Last		4 DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>19 61</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 12, 1915</b>
9 AGE (In years last birthday) <b>46</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>16</b> Hours <b>8</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Albert Haeffer</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Englehart</b>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Aortic stenosis, mitral stenosis</b> DUE TO <b>Rheumatic fever</b> DUE TO <b>35 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary atelectasis</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>May 15, 19 61</b> to <b>June 8, 19 61</b> that (I) (we) last saw the deceased alive on <b>June 8, 19 61</b> , and that death occurred at <b>2:25 PM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Robert J. Levine, M.D.</b>		22b. DATE SIGNED <b>6-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Levine M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>	23b. DATE THEREOF <b>6/9/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Middle Village New York</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
25a. REC'D BY REGISTRAR <b>DAT 1 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1. The funeral director or other person who has the body of the deceased in his possession at the time of death shall be responsible for the completion of this certificate. The funeral director or other person who has the body of the deceased in his possession at the time of death shall be responsible for the completion of this certificate. The funeral director or other person who has the body of the deceased in his possession at the time of death shall be responsible for the completion of this certificate.

MEDICAL CERTIFICATION



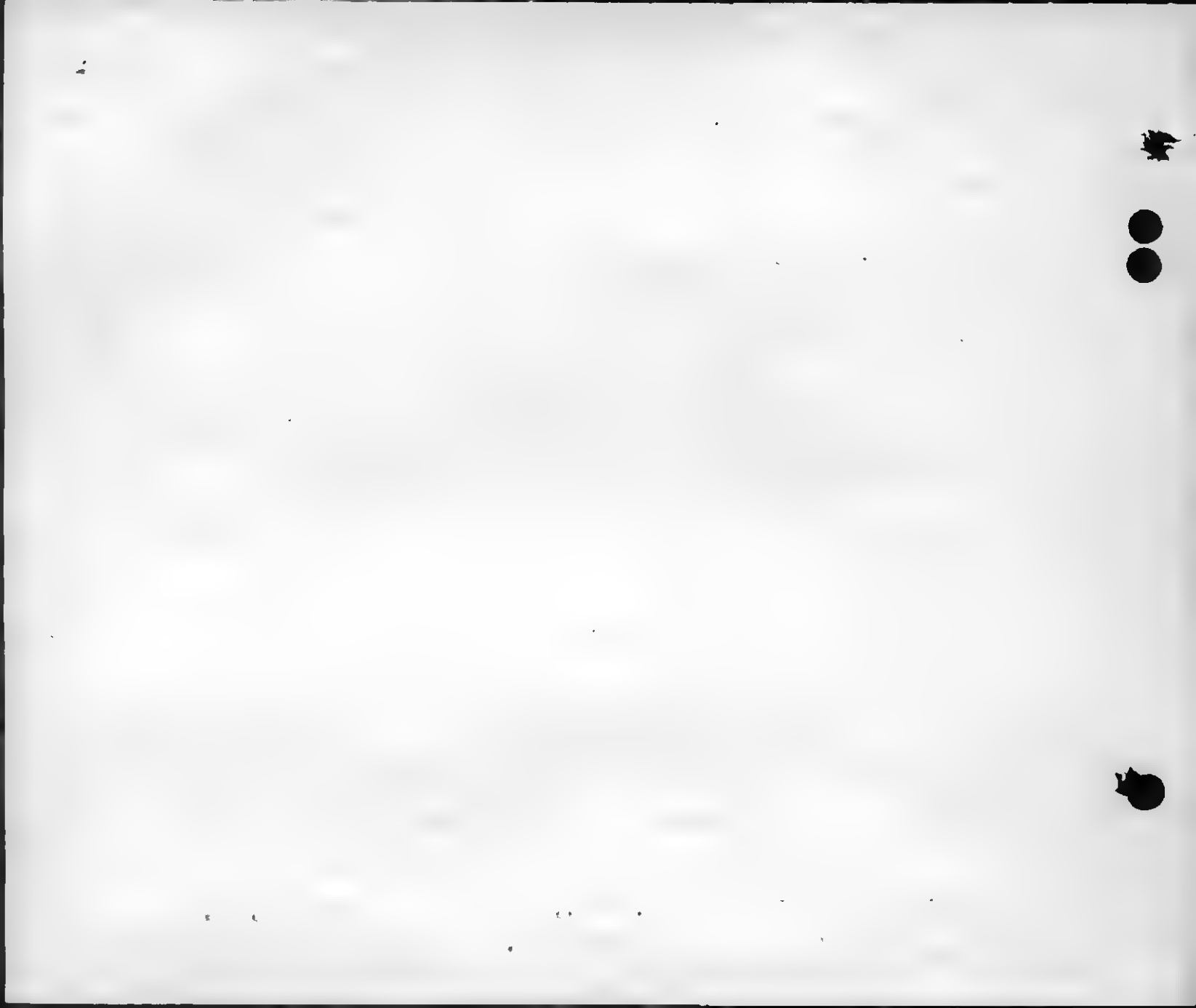
6982

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06968

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD3 Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD3, Gaithersburg</u>			
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>McDonald</u> Middle <u>McDonald</u> Last <u>McDonald</u>				4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 11, 1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Mc Donald</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Mason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Helen M. McDonald, Wife, RD3 Gaithersburg</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Varicose ulcer Lt. lower leg</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that (1) (his hospital) attended the deceased from <u>7-6</u> 19 <u>60</u> to <u>6-5</u> 19 <u>61</u> , that (1) (we) last saw the deceased alive on <u>7-6</u> 19 <u>60</u> , and that death occurred at <u>9:50</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Oliver G. Jackson,</u>				22b. DATE SIGNED <u>6-9-61</u>		22c. PHYSICIAN'S NAME (Type) <u></u>	
22d. ADDRESS <u>202 Martin Lay, Rockville Md.</u>				22e. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. ADDRESS <u></u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul.,</u>		23d. LOCATION (City, town, or county) (State) <u>Sugarland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u></u> DATE <u>JUN 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton L. Powers</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06969

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>8 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY ELLEN McDONALD</b>		4. DATE OF DEATH Month Day Year <b>JUNE 7 19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/19/1882</b>
9. AGE (In years last birthday) <b>78 yrs</b>		10. UNDER 1 YEAR Months Days Hours Min	11. UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND, BALTIMORE</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>ROBERT FREE</b>	
14. MOTHER'S MAIDEN NAME <b>SUSAN BARNES</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>INFARCTION of BRAIN (LEFT PARIETAL)</b> DUE TO <b>THROMBOSIS BASILAR ARTERY</b> DUE TO <b>GENERALIZED ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>8 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>8 days</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/31 7:55</b> to <b>6/2 1961</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C. H. L. L. RAN, M.D.</b>		22b. DATE SIGNED <b>6/7/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. B. BONIFANT, M.D.</b>		22d. ADDRESS <b>SANDY SPRING, MD.</b>	
23a. BURIAL, CREMATION, or other disposal (Specify)	23b. DATE THEREOF <b>June 10, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walter</b>		25. REC'D BY REGISTRAR <b>DATE JUN 9 '61</b>	
25a. ADDRESS <b>254 Carroll St. new 16C</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	





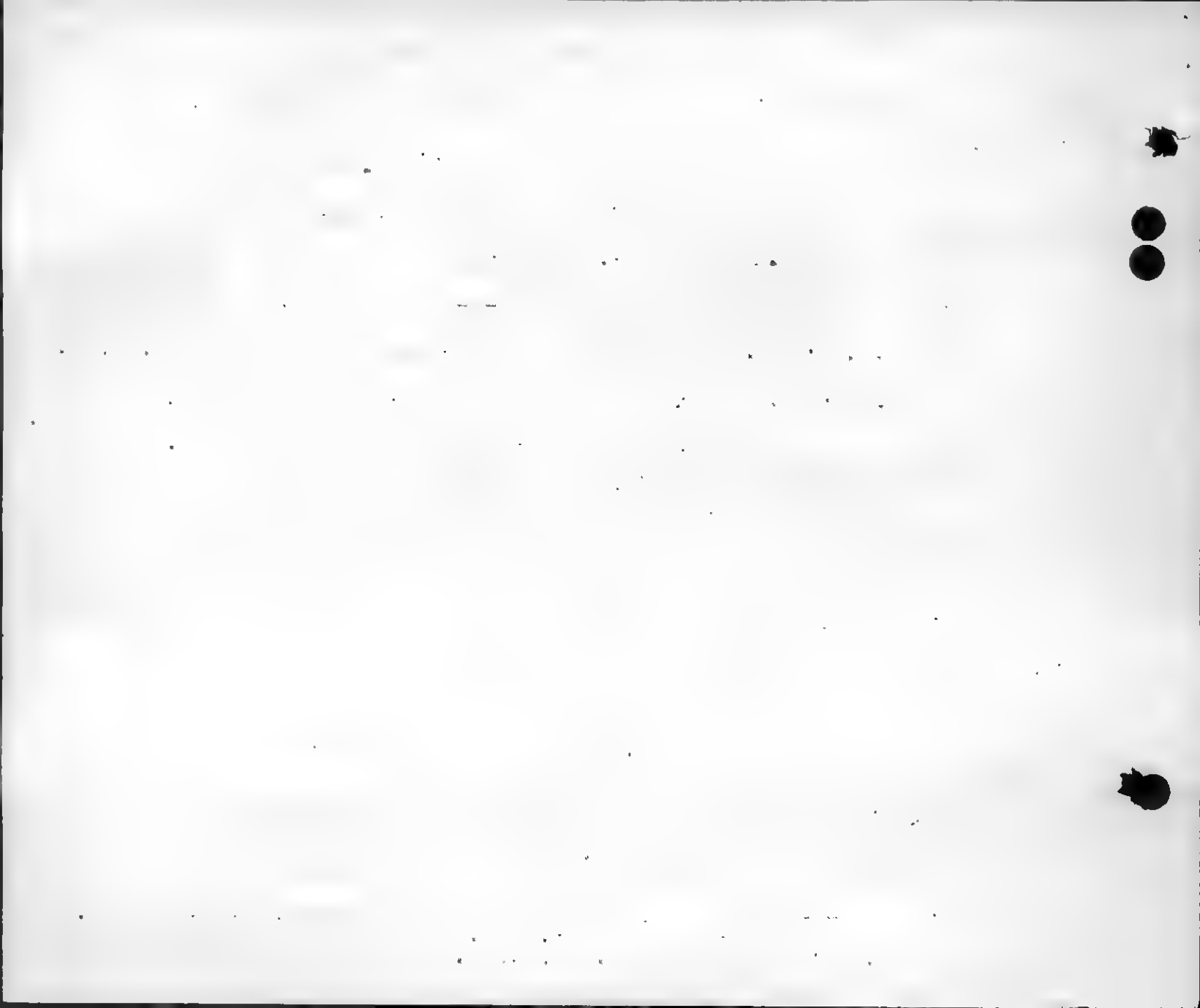
## CERTIFICATE OF DEATH

Reg. Dist. No. 06970

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>7300-Baltimore Ave</u> <u>Arz</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>9 months</u>		d. STREET ADDRESS <u>1901 Ingraham Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7300 Baltimore Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>P.</u> Last <u>McKEON</u>		4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-78</u>
9. AGE (In years last birthday) <u>83 yrs</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired U.S. Gov't.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MICHAEL J. McKEON</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET W. CRIPPS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
INFORMANT <u>Henrietta Dumas #8 Upland Rd. Everet,</u>		Address <u>Mass.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia -</u> <u>Renal Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-Sclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>3/18/56</u> , 19 <u>  </u> , to <u>6/2/61</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>6/2/61</u> , 19 <u>  </u> , and that death occurred at <u>855A</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4501 - Conn. Ave. N.W. Wash. D.C.</u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>James C. O'Keefe</u> M.D.		DATE SIGNED <u>  </u>	
PHYSICIAN'S NAME (Type) <u>James C. O'Keefe MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Everett Malden, MASS.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Collins</u> ADDRESS <u>WASH. D. C.</u>		24a. REC'D BY REGISTRAR <u>  </u>	
FRANCIS J. COLLINS 3821 14th. St. N. W.		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR A FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

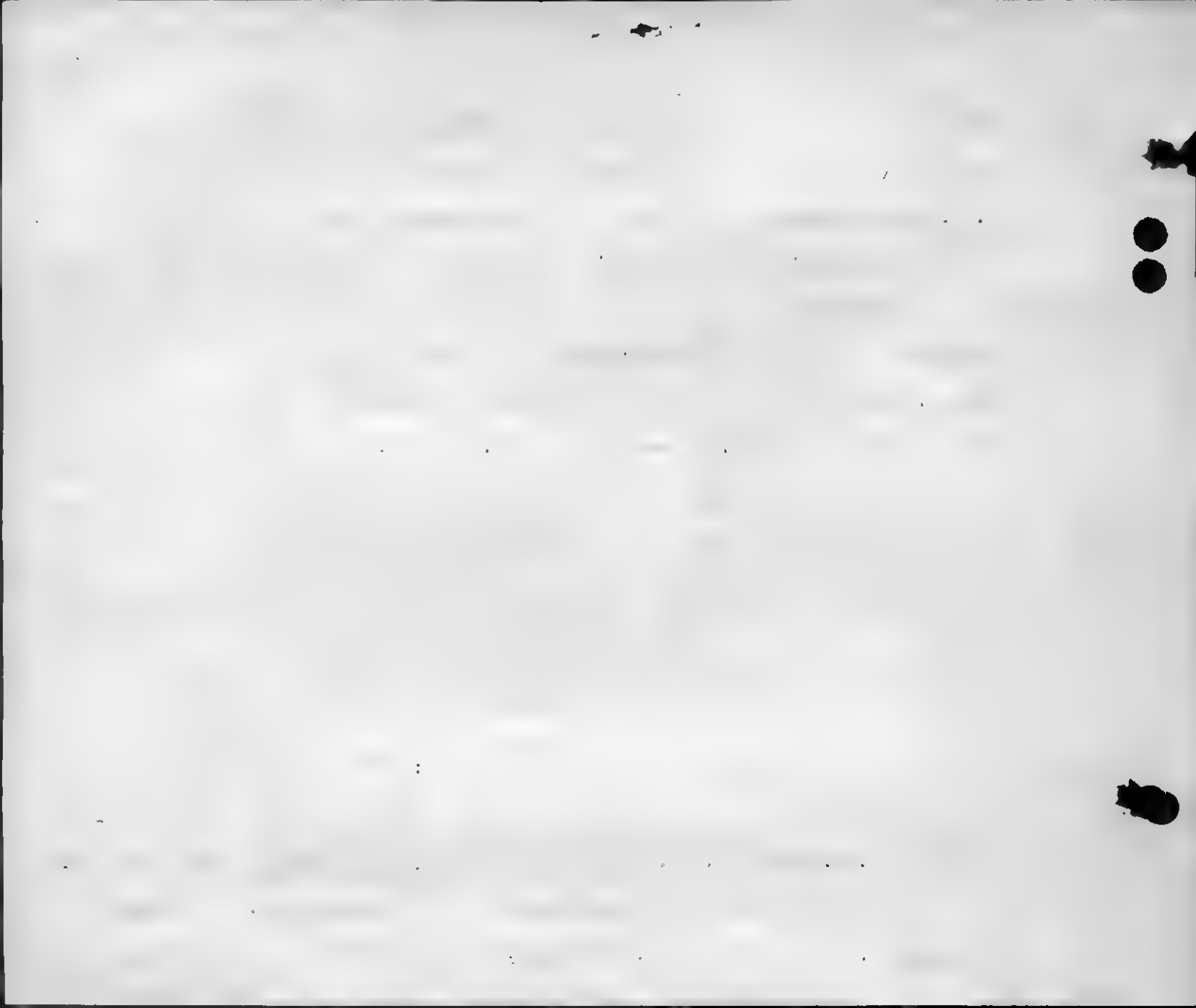
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6985

06971

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>35 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>113 Clyde Avenue</u>		<b>3. NAME OF DECEASED</b> (Type or print) <u>James</u> <u>Walter</u> <u>MEARS</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>12</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Caucasian</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3-5-30</u>		<b>9. AGE</b> (In years, if under 1 year, if under 24 hrs., last birthday) <u>31</u> yrs. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Repairman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Office Machines</u>		<b>11. BIRTHPLACE</b> County & State, or foreign country <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>James W. MEARS</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. CHANCE</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>5/51 to 3/52</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220-26-4129</u>		<b>17. INFORMANT</b> <u>(W) Mrs. Edoth C. Mears, same as #2 above</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary insufficiency</u> DUE TO (b) <u>rheumatic heart disease</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>		<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 8, 1961</u> to <u>June 12, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 12, 1961</u> and that death occurred at <u>6:25 AM</u> from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>B. H. Rice</u>		<b>22b. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>B. H. RICE, LT, MC, USN</u>		<b>22d. DATE SIGNED</b> <u>6-12-61</u>		<b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>22f. MED. DIRECTOR</b> <input type="checkbox"/> <b>22g. STAFF PHYS.</b> <input checked="" type="checkbox"/>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>June 15/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Wicomico Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Wicomico Co. Maryland</u>		<b>23e. (State)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Holloway &amp; Co., 414 E. Church St., Salisbury, Md.</u>		<b>24a. ADDRESS</b>		<b>24b. REC'D BY REGISTRAR</b>		<b>24c. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Funn</u>		<b>24d. DATE</b> <u>JUN 16 '61</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

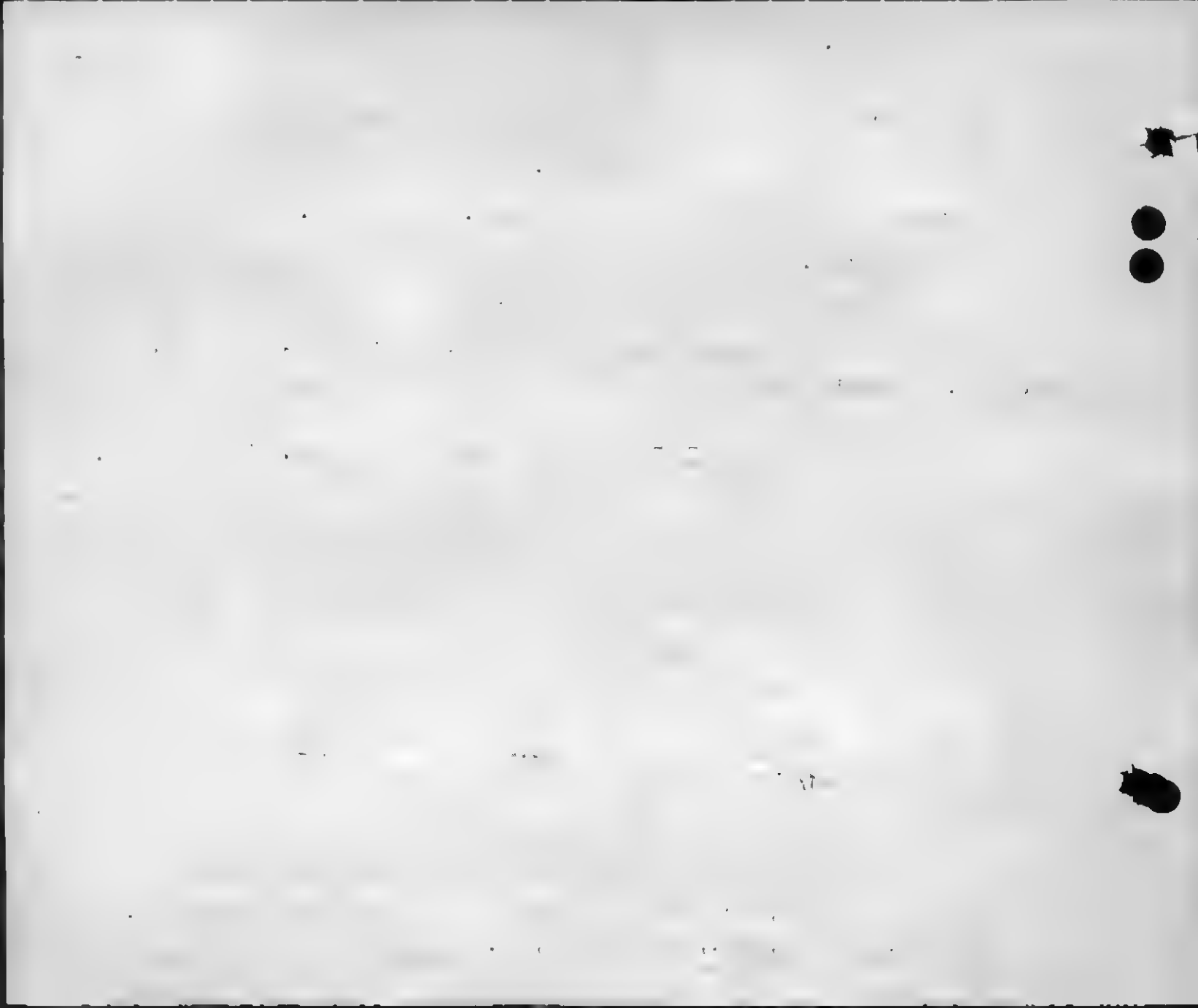
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06972

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>22 hours 15 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Atlantic City</u> d. STREET ADDRESS <u>64 S. Carolina Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Mary E. Mehan</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>June 17 1961</u>	
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/23/86</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Fur finisher (retired) Furrier</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Bird In Hand, Penn.</u>	<b>9. AGE</b> (in years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>John R. Frank-Wilson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown ? Knightie</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, <u>no</u> unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>150-09-3394</u>	
<b>17. INFORMANT</b> Address <u>Mary Auel 41 Maytide St. Pittsburgh, Pa.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> (b) <u>hypertensive cardiovascular disease</u> (c) <u>36 hours unknown years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19 June 16 1961</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from June 16 1961 to June 17 1961, that (I) (we) last saw the deceased alive on June 17 1961, and that death occurred on June 17 1961, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>G. Bowditch Hunter, Jr. M.D.</u>		<b>22b. DATE SIGNED</b> <u>6/17/61</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>G. Bowditch Hunter, Jr. M.D.</u>		<b>22d. ADDRESS</b> <u>809 Veirs Mill Rd. Rockville, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>June 21, 1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Montgomery County, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A. Ziska</u>		<b>25a. REC'D BY REGISTRAR</b> <u>June 26 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>		<b>25c. ADDRESS</b> <u>Silver Spring, Md.</u>	

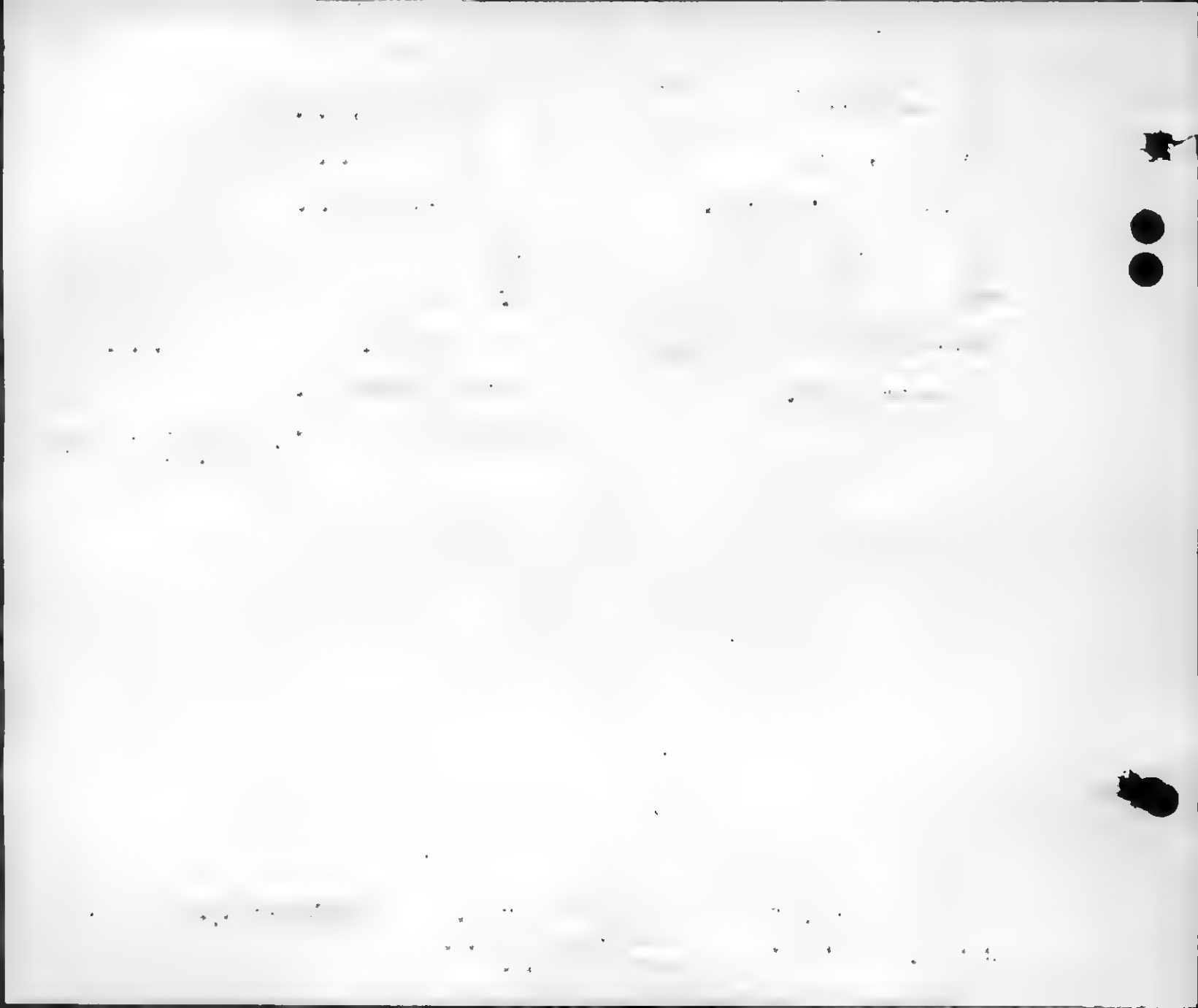


6987

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH <b>CARROLL MALL REST HOME</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>MONTGOMERY</b>	MARYLAND	a. STATE <b>WASHINGTON, D.C.</b>	b. COUNTY <input checked="" type="checkbox"/>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON, MD</b>	c. LENGTH OF STAY IN TB <b>6 YRS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MALL REST HOME.</b>		d. STREET ADDRESS <b>1427 MONROE ST N.E.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JOHANNA</b>		4. DATE OF DEATH <b>JUNE 27 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 4 1876</b>
9. AGE (In years last birthday) <b>84 yrs</b>		10. IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>GERMANY.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>AUGUST RAWLIN.</b>	
14. MOTHER'S MAIDEN NAME <b>JOHANNA SCHOEMACHER.</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT <b>MR FRED ERICK A RAWLIN.</b> Address <b>13010 COLESVILLE ROAD</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		18. BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC 6</b> , 1955, to <b>JUNE 27, 1961</b> , that I last saw the deceased alive on <b>JUNE 27, 1961</b> , and that death occurred at <b>7:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry Louis</b> M.D.		ADDRESS (Street, city or town, state) <b>520 G. N. Highway Dr.</b> DATE SIGNED <b>6/27/61</b>	
PHYSICIAN'S NAME (Type) <b>Cherry Chase, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/30/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY.</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C. PR GEO CO MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.K. HUNTEMANN &amp; SON.</b>		24a. REG'D BY REGISTRAR <b>JUN 29 61</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

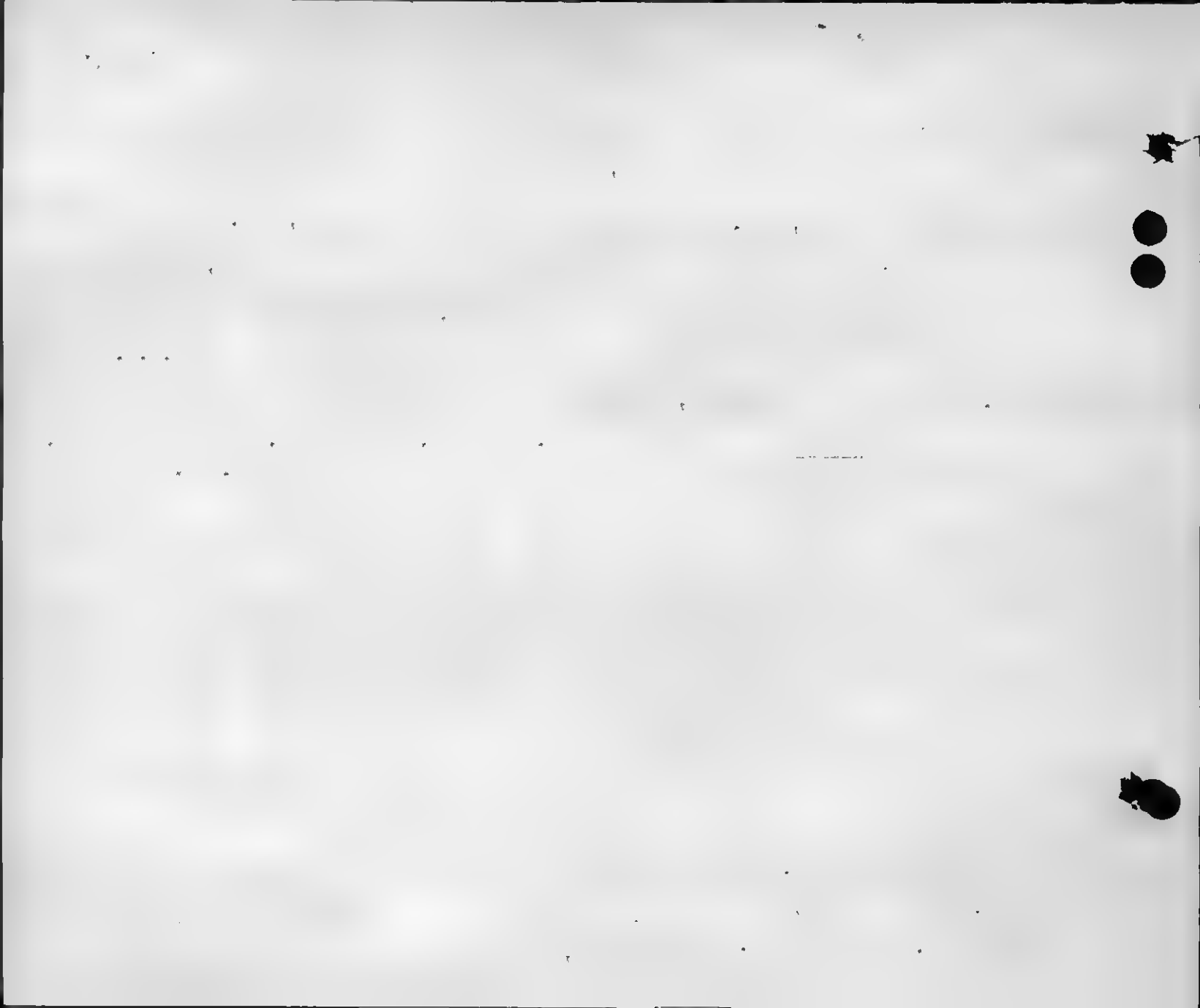
## CERTIFICATE OF DEATH

6988

66974

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>May 15, 1961</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5300 Westbard Avenue, Apt. 302 Westwood</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5300 Westbard Avenue, Apt. 302</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Irene Henry Messall</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Enid Ohio U.S.A.</u>		<b>4. DATE OF DEATH</b> <u>June 8, 1961</u> 8. DATE OF BIRTH <u>April 16, 1899</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Mr. Homer Henry Louisiana, Missouri</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Mr. Victor R. Messall Apt. 302 Westwood Apts. 5300 Westbard Avenue Westwood, Md.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Russell Kansas</u> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Arteriosclerosis</u> (c) <u>1 day</u> DUE TO <u>2 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town) (County) (State)</b> <u>  </u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>April 6, 1961</u> <b>to</b> <u>June 8, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>June 8, 1961</u> <b>and that death occurred</b> <u>8:30 AM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>John J. Curry</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>JOHN J. CURRY</u>		<b>22b. DATE SIGNED</b> <u>6/8/61</u> <b>22d. ADDRESS</b> <u>10620 Georgia Ave S.S. Ind</u>	
<b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b> <u>Burial 6/12/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>	
<b>23d. LOCATION</b> (City, town or county) (State) <u>Montgomery County, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Raymond A. Zeller</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Humphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kline</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



6089

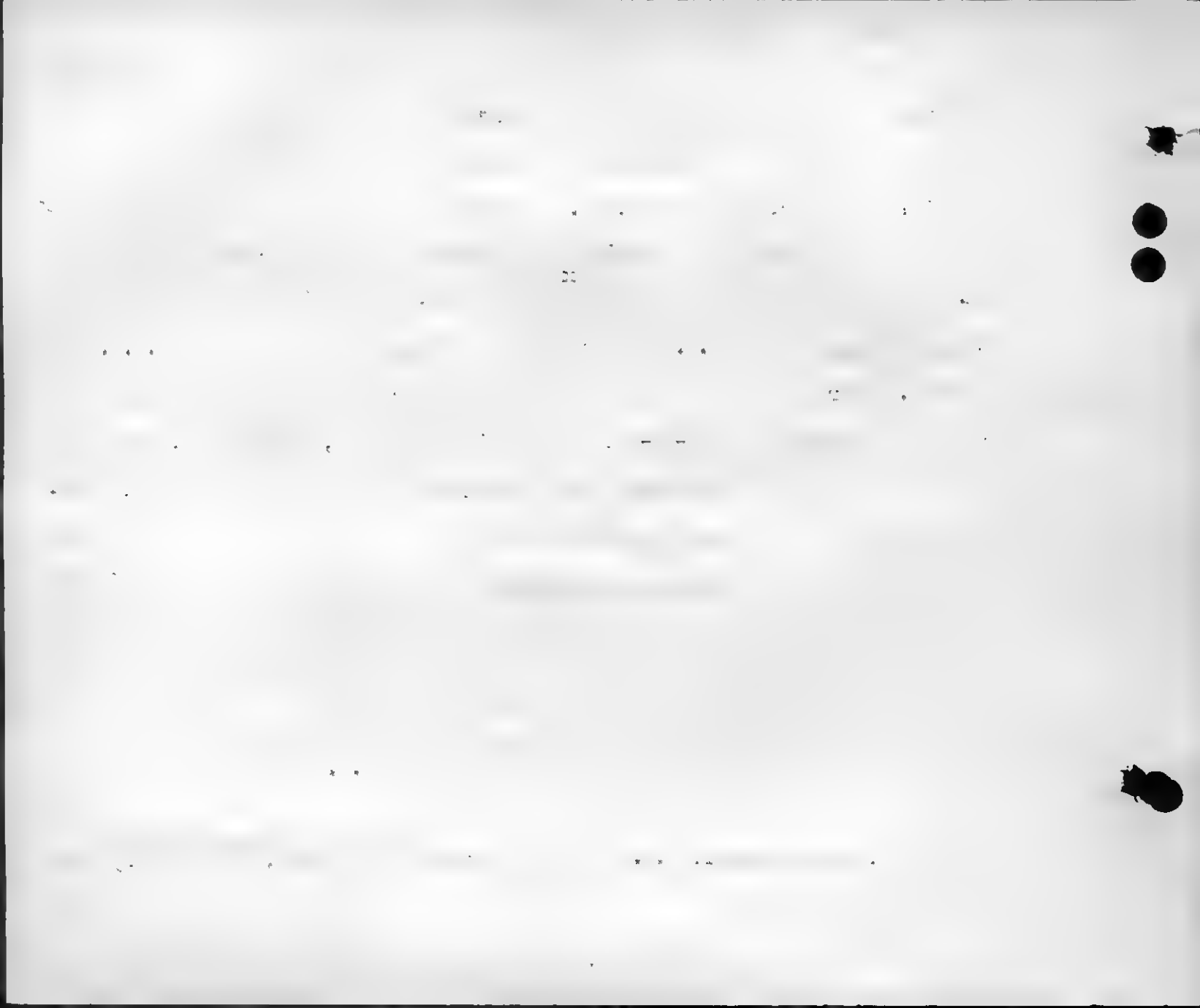
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

06975

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Indiana</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>27 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Box 168</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Louise</b> Last <b>Meyer</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 26, 1924</b>	
9. AGE (In years last birthday) <b>36</b> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Captain (Nurse)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Air Force</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George J. Meyer</b>				14. MOTHER'S MAIDEN NAME <b>Anna Mayer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Present</b>				16. SOCIAL SECURITY NO <b>308-22-5118</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Intestinal Obstruction</b> DUE TO (c) <b>Carcinoma of Rectum</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>2 weeks</b> <b>3 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 24</b> 19 <b>61</b> to <b>June 20</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>June 20</b> 19 <b>61</b> , and that death occurred at <b>9:35 p.m.</b> from the causes and on the date stated above							
22a. SIGNATURE <i>W. Walter Oppelt</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. WALTER OPPELT, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>24 JUNE 1961</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>HAUBSTADT INDIANA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. WALDI FUNERAL HOME INC.</b>				ADDRESS <b>816 H &amp; N E. RD</b>		25a. REC'D BY REGISTRAR <b>JUN 23 '61</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>			

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORONER NOTIFIED AND WILL APPROVE.

<div>1</div> <div>MD</div> <div>6590</div> <div> <div>1</div> <div>MD</div> <div>6590</div> </div>									
<div> <div>1</div> <div>MD</div> <div>6590</div> </div> <div> <div>1</div> <div>MD</div> <div>6590</div> </div>									
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Montgomery</div> <div>MARYLAND</div>					<div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Washington</div>				
<div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Silver Spring</div> <div>c. LENGTH OF STAY IN 1b</div> <div>4 days</div>					<div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Hagerstown</div> <div>d. STREET ADDRESS</div> <div>330 West Side Ave</div>				
<div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)</div> <div>2224 Washington Avenue</div>					<div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>				
<div>3. NAME OF DECEASED (Type or print)</div> <div>Irvin RAY Middlekauff</div>					<div>4. DATE OF DEATH</div> <div>June 14 19 61</div>				
<div>5. SEX</div> <div>Male</div>					<div>6. COLOR OR RACE</div> <div>White</div>				
<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>					<div>8. DATE OF BIRTH</div> <div>Nov. 25, 1883</div>				
<div>9. AGE (in years last birthday)</div> <div>77 yrs</div>					<div>10. IF UNDER 1 YEAR</div> <div>Months 6 Days 9</div>				
<div>11. IF UNDER 24 HRS.</div> <div>Hours Min.</div>					<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div>				
<div>13. FATHER'S NAME</div> <div>Daniel J. Middlekauff</div>					<div>14. MOTHER'S MAIDEN NAME</div> <div>Amelia Margaret Downin</div>				
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)</div> <div>No</div>					<div>16. SOCIAL SECURITY NO</div> <div>219-20-1458</div>				
<div>17. INFORMANT</div> <div>Stella Middlekauff-wife-same 2d</div>					<div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>CEREBRAL THROMBOSIS</div> <div>332X</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b)</div> <div>ARTERIOSCLEROSIS GENERALIZED</div> <div>(c)</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>26 HRS.</div>				
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</div>									
<div>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)</div>					<div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>19</div>				
<div>20d. INJURY OCCURRED</div> <div>Where at work <input type="checkbox"/> Not where at work <input type="checkbox"/></div>					<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div>				
<div>21. I certify that (I) (this hospital) attended the deceased from 13 Jun 1961 to 14 Jun 1961 that (I) (we) last saw the deceased alive on 13 JUNE 1961, and that death occurred at 1020 AM from the causes and on the date stated above.</div>									
<div>22a. SIGNATURE</div> <div>Marshall Cuvillier, Jr. MD</div>					<div>22b. DATE SIGNED</div> <div>14 Jun 61</div>				
<div>22c. PHYSICIAN'S NAME (Type)</div> <div>L. Marshall Cuvillier, Jr</div>					<div>22d. ADDRESS</div> <div>1407 Woodside Pkwy. Silver Spring</div>				
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>					<div>23b. DATE THEREOF</div> <div>6/16/61</div>				
<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Rose Hill Cemetery</div>					<div>23d. LOCATION (City, town or county)</div> <div>Hagerstown, Maryland</div>				
<div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>Andrew K. Goffman</div>					<div>25a. REC'D BY REGISTRAR</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>19 61</div>				



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

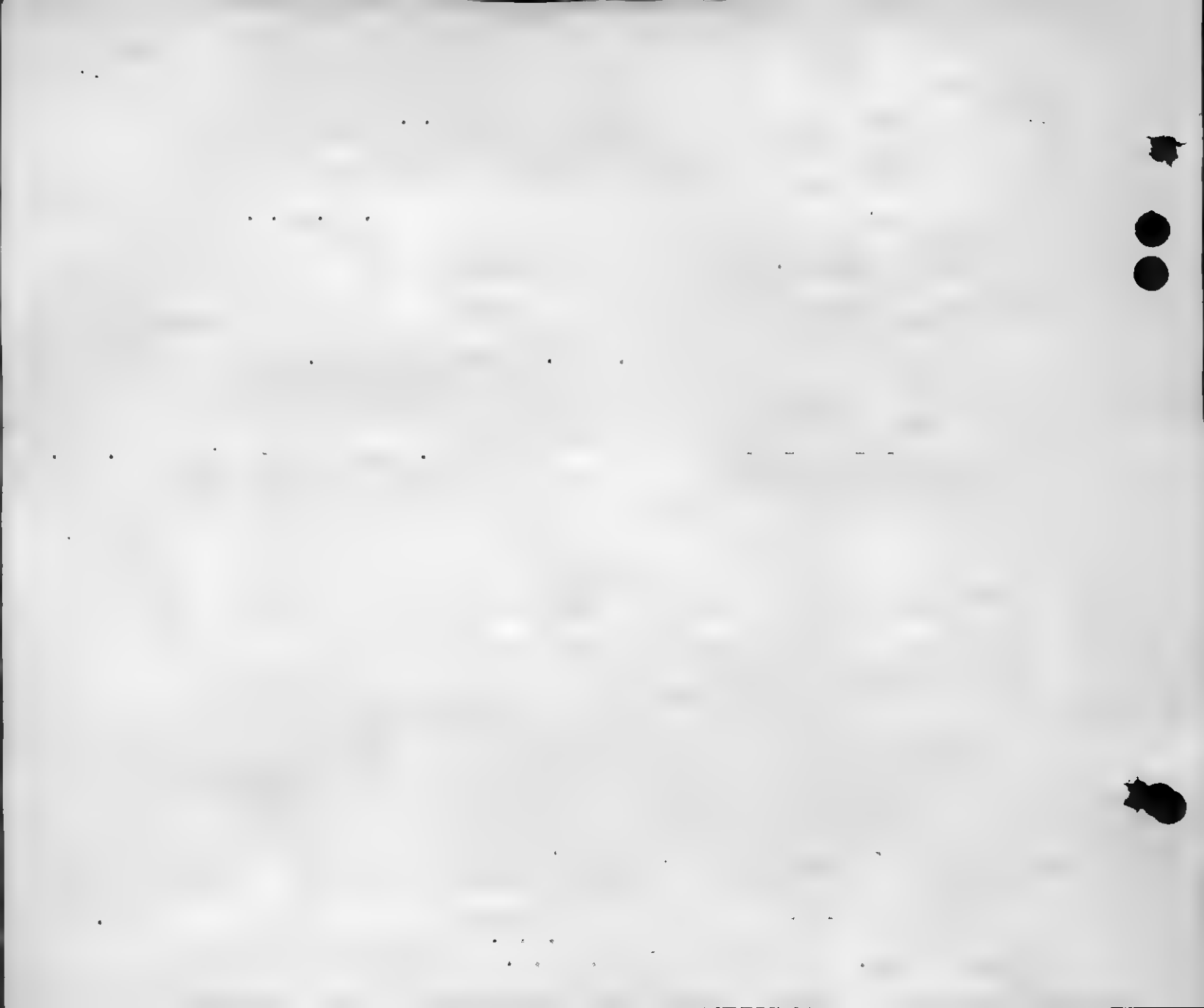
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06973

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>10 1/2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1417 N. St., N.W. Apt 500</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Salvatore John</u> First Middle Last 4. DATE OF DEATH <u>Mistretta</u> Month <u>6</u> Day <u>27</u> Year <u>19 61</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/12/17</u> 9. AGE (In years last birthday) <u>43</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. RAILROAD</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D. C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN MISTRETTA</u> 14. MOTHER'S MAIDEN NAME <u>MELBA MISTRETTA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>5-77-10-9302</u> 17. INFORMANT <u>WILLIAM MISTRETTA</u> Address <u>243 1st St. N.W. Silver Spring, Md.</u>		18. CAUSE OF DEATH (Enter only one cause prevailing for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Brochogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (b) <u>with extensive regional metastases</u> DUE TO <u>several months</u> (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>WASHINGTON CLINIC</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/15</u> to <u>6/27</u> , 19 <u>61</u> , that (I) <u>was</u> last saw the deceased alive on <u>6/27</u> , 19 <u>61</u> , and that death occurred at <u>2:00</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Michael M. Healy</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>MICHAEL M. HEALY</u> 22b. DATE SIGNED <u>6/27/61</u> 22d. ADDRESS <u>WASHINGTON CLINIC</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>urial</u> 23b. DATE THEREOF <u>6-30-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u> 23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Collins</u> ADDRESS <u>1417 N. St., N.W.</u> 25a. REC'D BY REGISTRAR <u>JUN 30 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

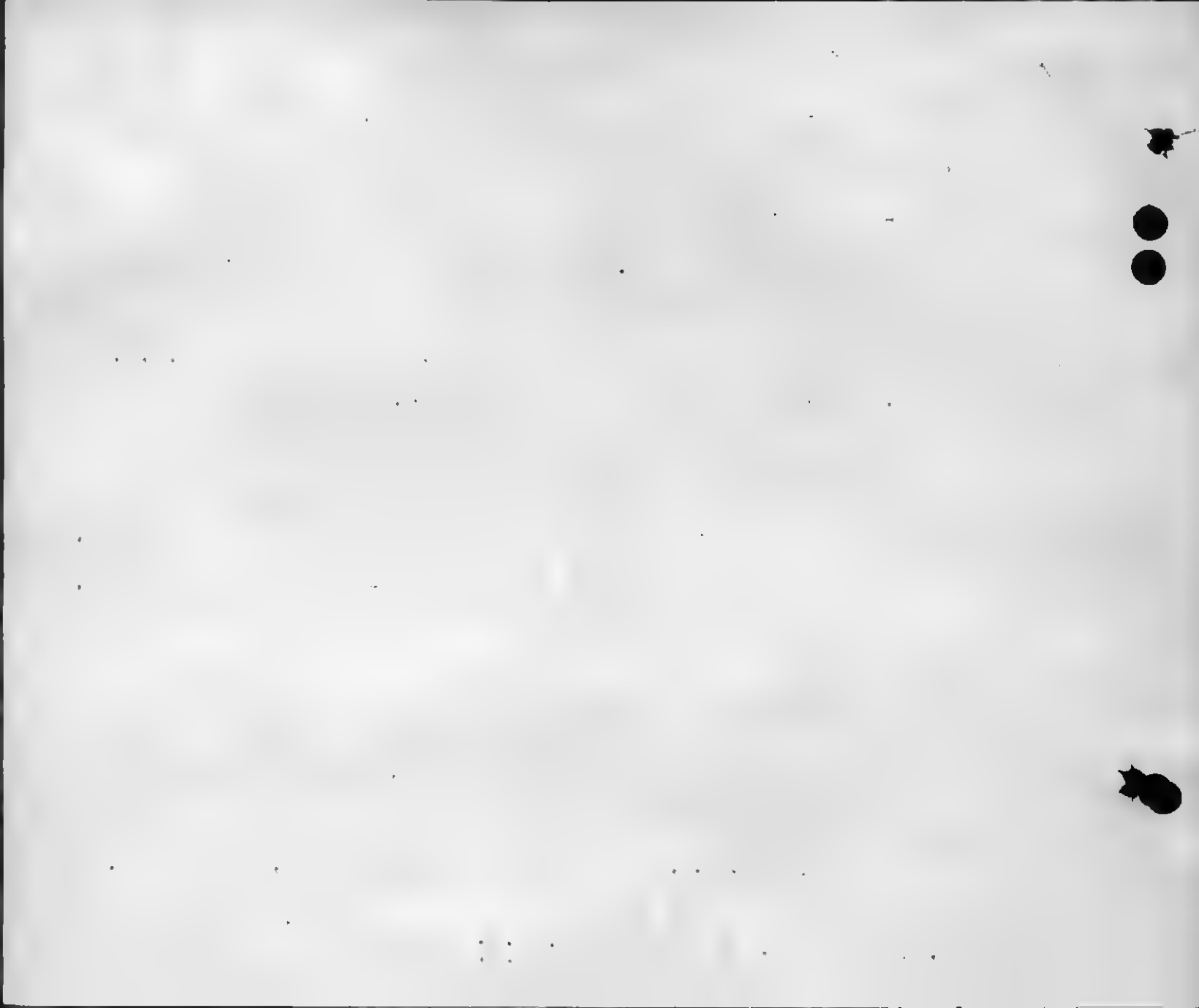
## CERTIFICATE OF DEATH

6992

06979

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7110 - 45th Street</b>		2. USUAL RESIDENCE (Where deceased lived, if last but on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>7110 45th Street</b>	
3. NAME OF DECEASED (Type or print) <b>CLARA B. MORRIS</b> 4. DATE OF DEATH <b>June 7, 1961</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>5/4/69</b> 9. AGE (in years, if UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) <b>92</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b> 11. BIRTHPLACE (County & State or foreign country) <b>Tonica, Illinois</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William B. Boyley</b>		14. MOTHER'S MAIDEN NAME <b>Sarah J. Potter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b> 17. INFORMANT <b>Alta Marie Morris</b> Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b> DUE TO (b) <b>Senile dementia</b> DUE TO (c) <b>Cerebral &amp; generalized arterio-sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe osteo arthritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>4 mos.</b> <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug-Dec 1959</b> , to <b>7 June 1961</b> , that (I) (we) last saw the deceased alive on <b>6 June 1961</b> , and that death occurred at <b>12:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John G. Ball</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John G. Ball, M.D.</b>		22d. ADDRESS <b>7936 Georgetown Rd., Bethesda, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>removal</b>		23b. DATE THEREOF <b>6/8/61</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <b>Tonica, Illinois</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>25b. REGISTRAR'S SIGNATURE</b> <b>2901 14th St. N.W. Washington 9, D.C.</b> <b>DATE JUN 8 '61</b> <b>Charles E. Kneass</b>	

VR A15 (4)  
15M 9/60



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN Ill <b>5/21/61</b>		d. STREET ADDRESS <b>6348 - 31st Place N.W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wheaton Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LILLIE</b>		4. DATE OF DEATH <b>6 21 19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>7/1/1865</b>		9. AGE (In years last birthday) <b>95</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MOURER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Carlisle, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hartman</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Guise</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Elsie M. Bixler - Washington, D.C.</b>		Address <b>6348-31st Pl. NW</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis - generalized</b> (c) DUE TO <b>Arteriosclerosis - generalized</b> cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... 19... to... 19..., that (I) (we) last saw the deceased alive on... 19..., and that death occurred at... M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry N. Carlton</b>		22b. DATE SIGNED <b>6/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry N. Carlton</b>		22d. ADDRESS <b>1522 Flora Ct. Sil. Sp. Md.</b>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <b>Burial 16/24/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Carlisle, Penna.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company - Washington, D.C.</b>	
25a. REC'D BY REGISTRAR <b>JUN 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



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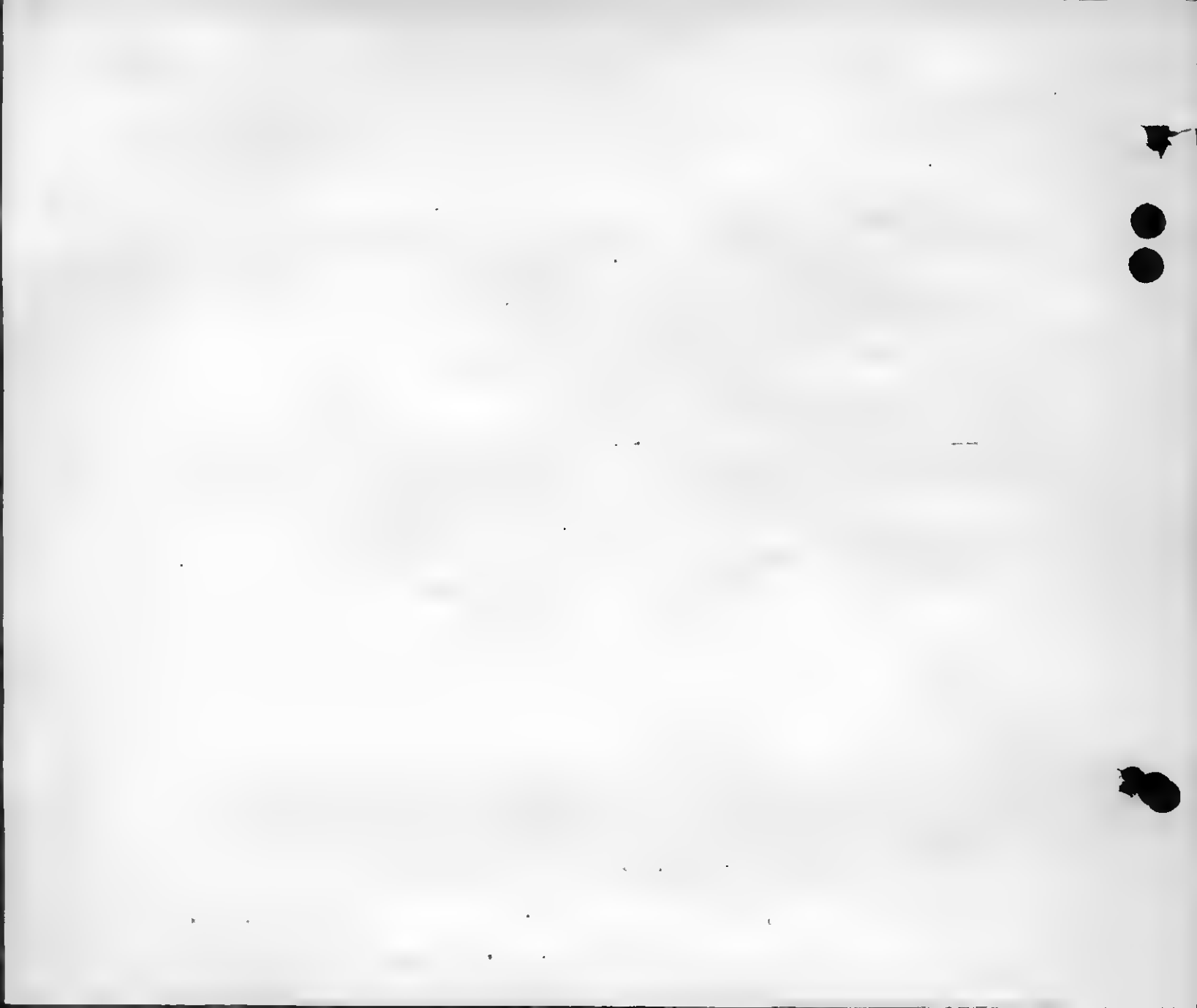
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6894

06981

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>25 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>M.</b> Last <b>NEWMAN</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-22-1895</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b> Hours <b>12</b> Min.	IF UNDER 24 HRS Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WILLIAM E. SMITH</b>				14. MOTHER'S MAIDEN NAME <b>LAURA O. Ogle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis, Laennec's one</b> <b>581.1</b> DUE TO <b>OF LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>OF LIVER</b> (c) <b>Bronchopneumonia, Bilateral</b>							INTERVAL BETWEEN ONSET AND DEATH <b>One Month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>S</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-18-1961</b> to <b>6-12-1961</b> that (I) (we) last saw the deceased alive on <b>6-11-1961</b> and that death occurred at <b>2:30</b> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Jack Schumacher</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M. D.</b>				22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 15, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Little Vine</b>		23d. LOCATION (City, town, or county) (State) <b>Sylvester, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John L. Nichols</b> ADDRESS <b>Damascus, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be filled out within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

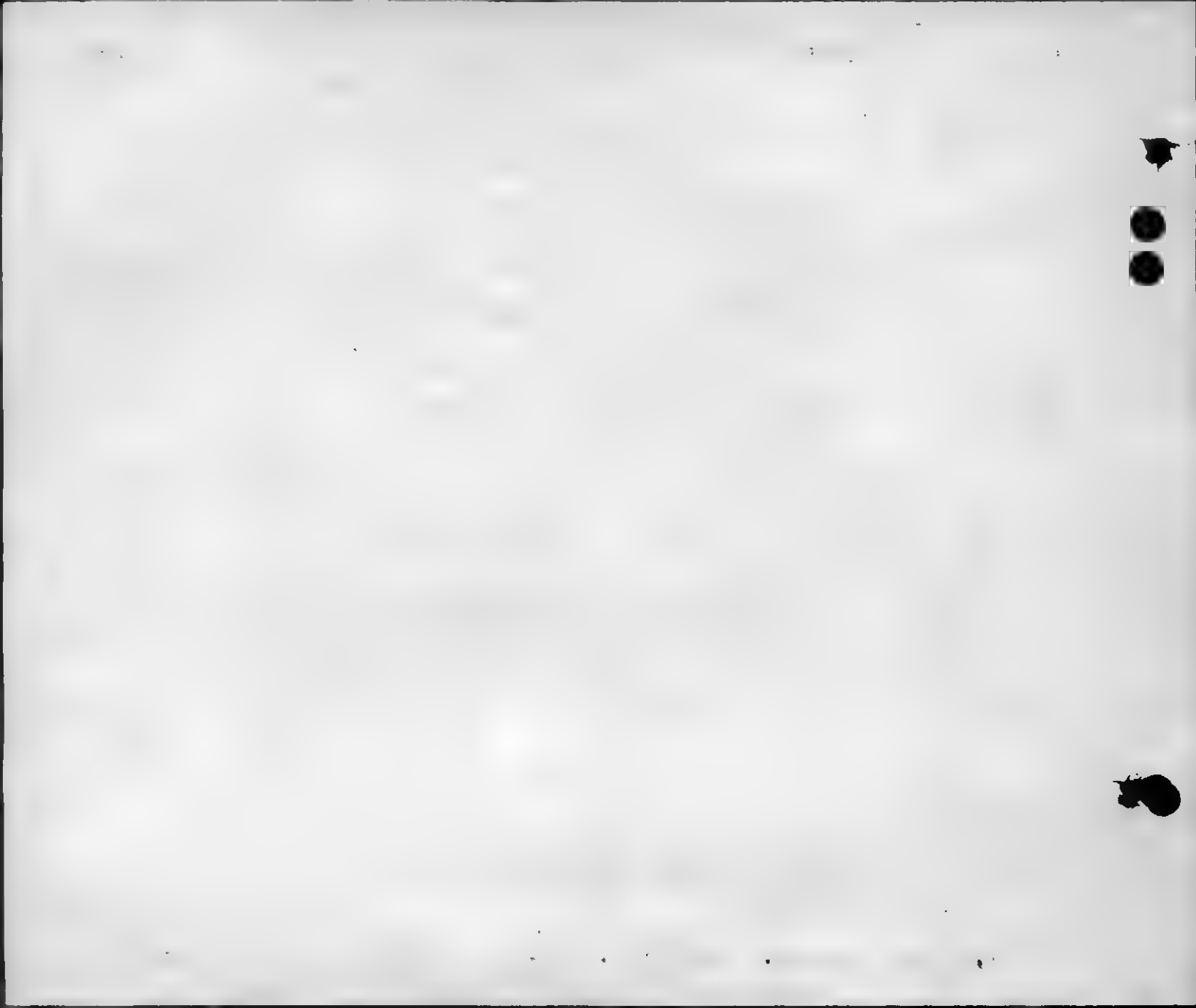
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6995

06982

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sen &amp; Hosp</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> d. STREET ADDRESS <u>139 Ritchie Ave</u>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>LENA</u> <u>JAMES Nicholson</u>		<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>4</u> Year <u>1961</u>									
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6/23/19</u>								
<b>9. AGE</b> (In years last birthday) <u>43</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>maid</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>North Carolina</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Amer.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>13. FATHER'S NAME</b> <u>JAMES MOORE</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Clemmie Hill</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>710</u> <b>17. INFORMANT</b> <u>Pt Charx</u> Address _____									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC TAMPONADE</u> <u>022X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>RUPTURED AORTIC ANEURYSM</u> (c) <u>causing the underlying cause last.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____									
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a.m. p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____	<b>20f. (City or town)</b> _____ (County) _____ (State) _____								
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>MAY 21</u> , 19 <u>61</u> , to <u>JUNE 4</u> , 19 <u>61</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>JUNE 3</u> , 19 <u>61</u> , and that death occurred at <u>7:45</u> A.M., from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>MORRILL C. QUINNAM JR.</u> M.D.		<b>22b. DATE SIGNED</b> <u>5-4-61</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>MORRILL C. QUINNAM JR.</u>		<b>22d. ADDRESS</b> <u>7600 CARROLL AVE. THADOM PARK, MD.</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>6/9/1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ship To -</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Scotland Neck, North Carolina</u>								
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. Ernest Jarvis Co.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>John R. Risher</u> <u>653</u> <u>1432 You St., N.W.</u>									
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur J. Hines</u>		<b>25c. DATE</b> <u>JUN 15 '61</u>									





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

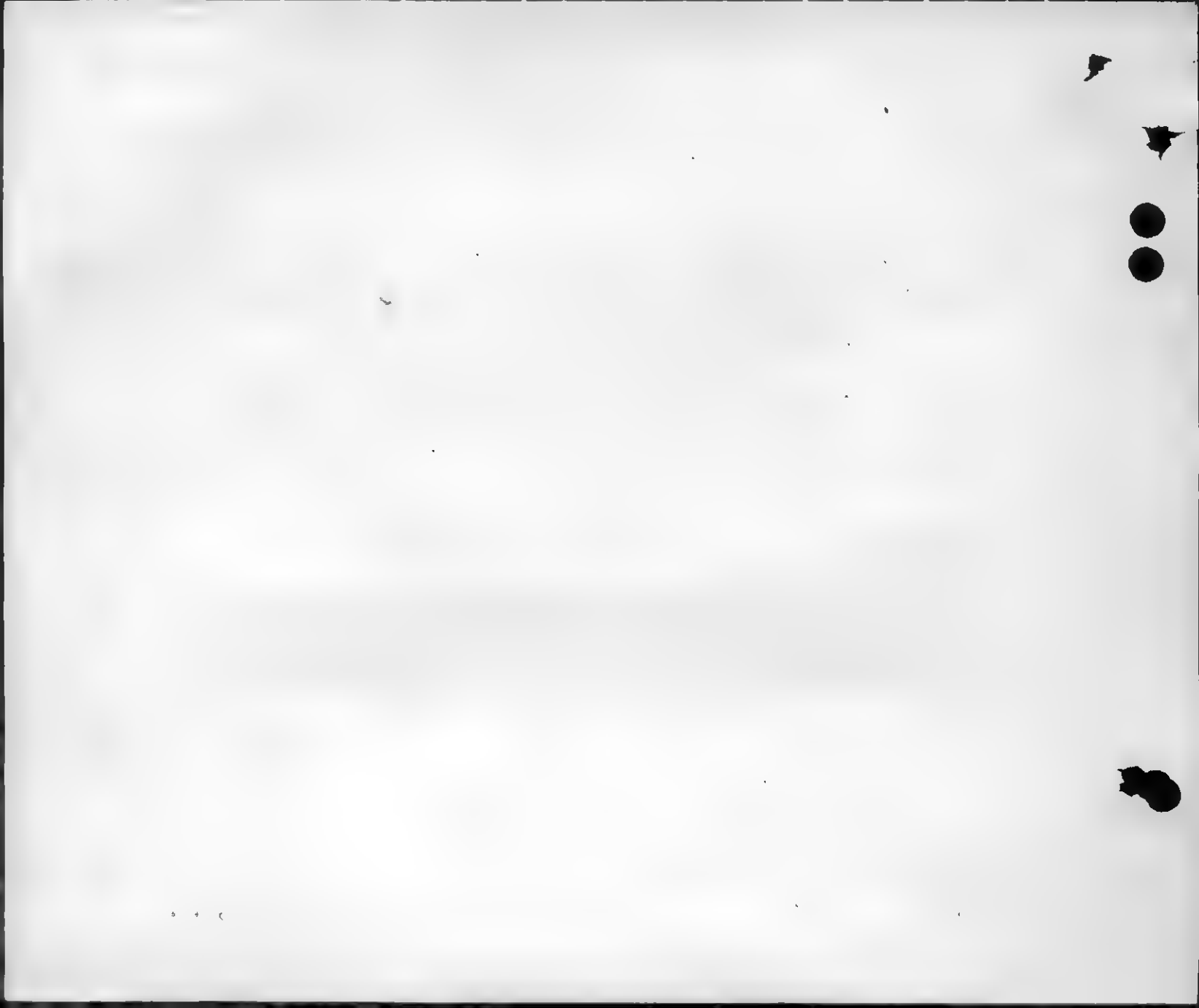
**CERTIFICATE OF DEATH**

6995

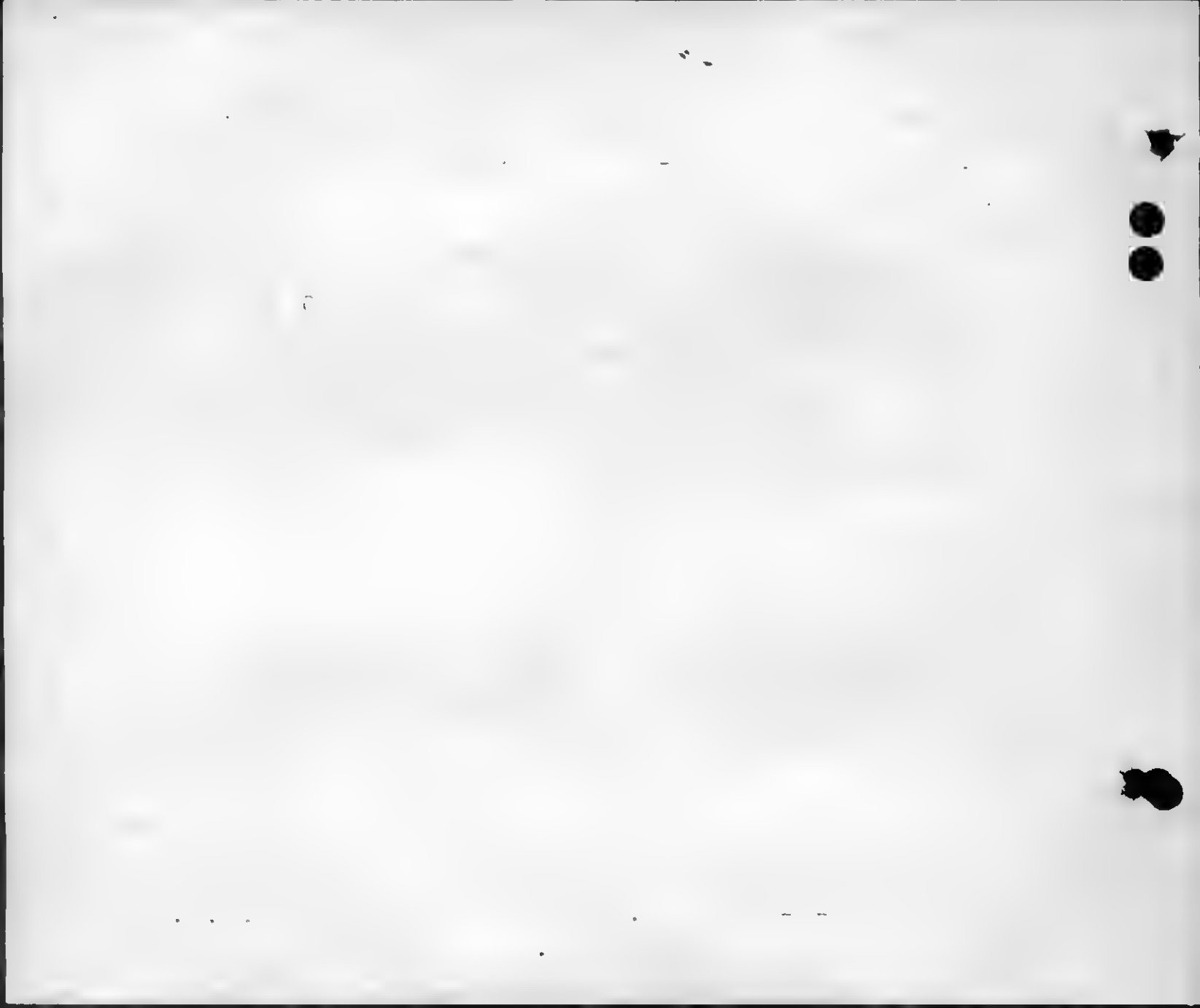
06983

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clney</u> c. LENGTH OF STAY IN 1b <u>3 yrs 2 mo</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Funeral Home Inc</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47</u> d. STREET ADDRESS <u>The Dresden 2126 Connecticut Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Portia Meredith Oberly</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 4 1874</u> 9. AGE (In years last birthday, yrs) <u>87</u> 10. IF UNDER 1 YEAR Months Days Hours Min 11. IF UNDER 24 HRS Hours Min		4. DATE OF DEATH <u>June 5 1961</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John H. Oberly</u> 14. MOTHER'S MAIDEN NAME <u>Helen Sakuckers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Mrs Virginia Malone</u> Address <u>McRiches Rd. St. James L.I. N.Y.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 572 DUE TO <u>Chronic nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis, Residual polio myelitis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>10/25</u> <u>5:55 AM</u> to <u>6/5</u> <u>1961</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> <u>1961</u> , and that death occurred on <u>6/5</u> <u>1961</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>C. H. Wigton</u> 22b. DATE SIGNED <u>6/5/61</u> 22c. PHYSICIAN'S NAME (Type) <u>C. H. Wigton</u> 22d. ADDRESS <u>Sandy Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>6/7/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u> 23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawler's Son</u> ADDRESS <u>1756 Pa Ave. Wash. D.C.</u> 25a. REC'D BY REGISTRAR <u>DATE JUN 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur P. Kraus</u>	

MEDICAL CERTIFICATION







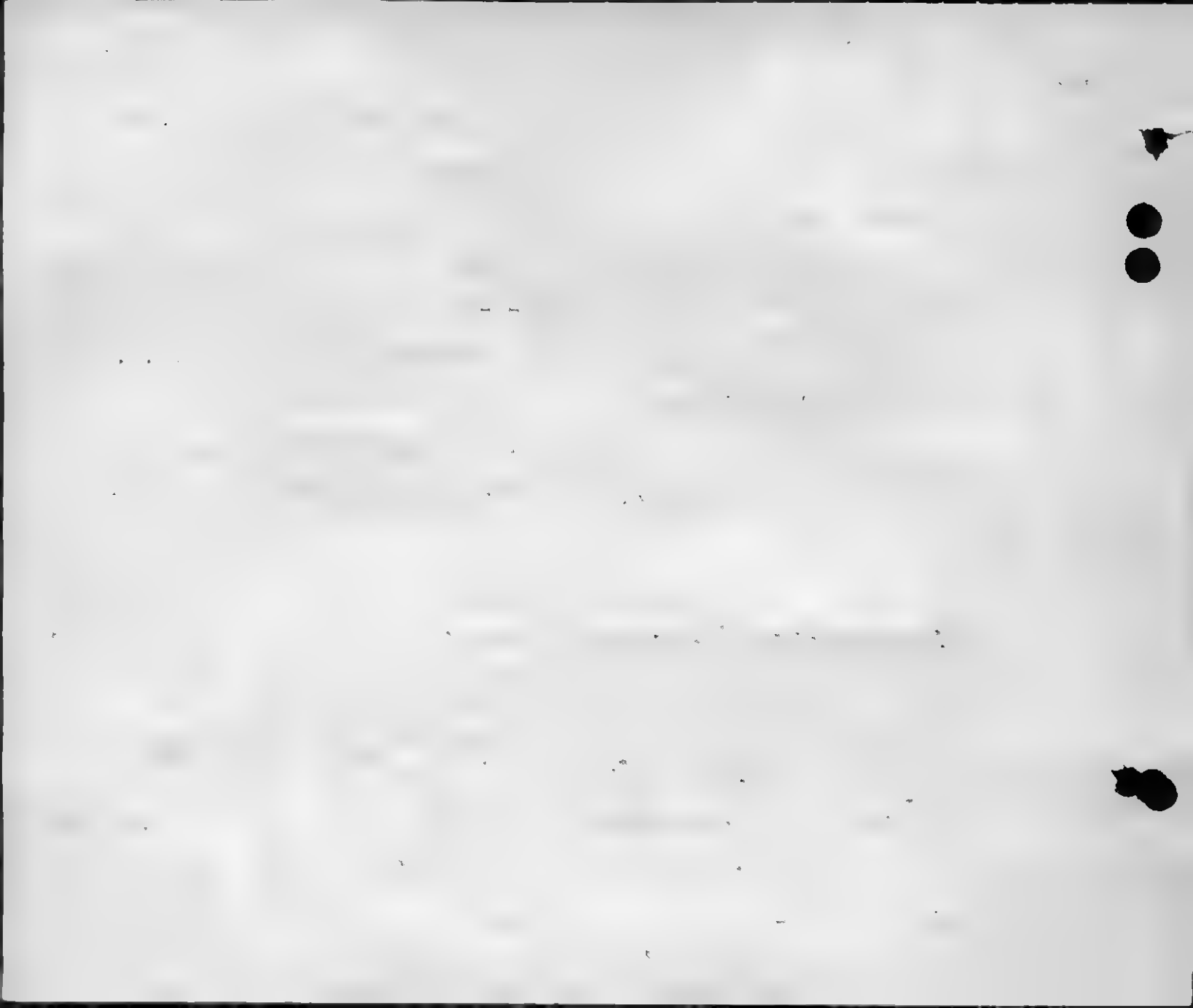
VII A15 (4)  
15M 9/60

VII A15 (4)  
15M 9/60

# NOF STAFF

06985

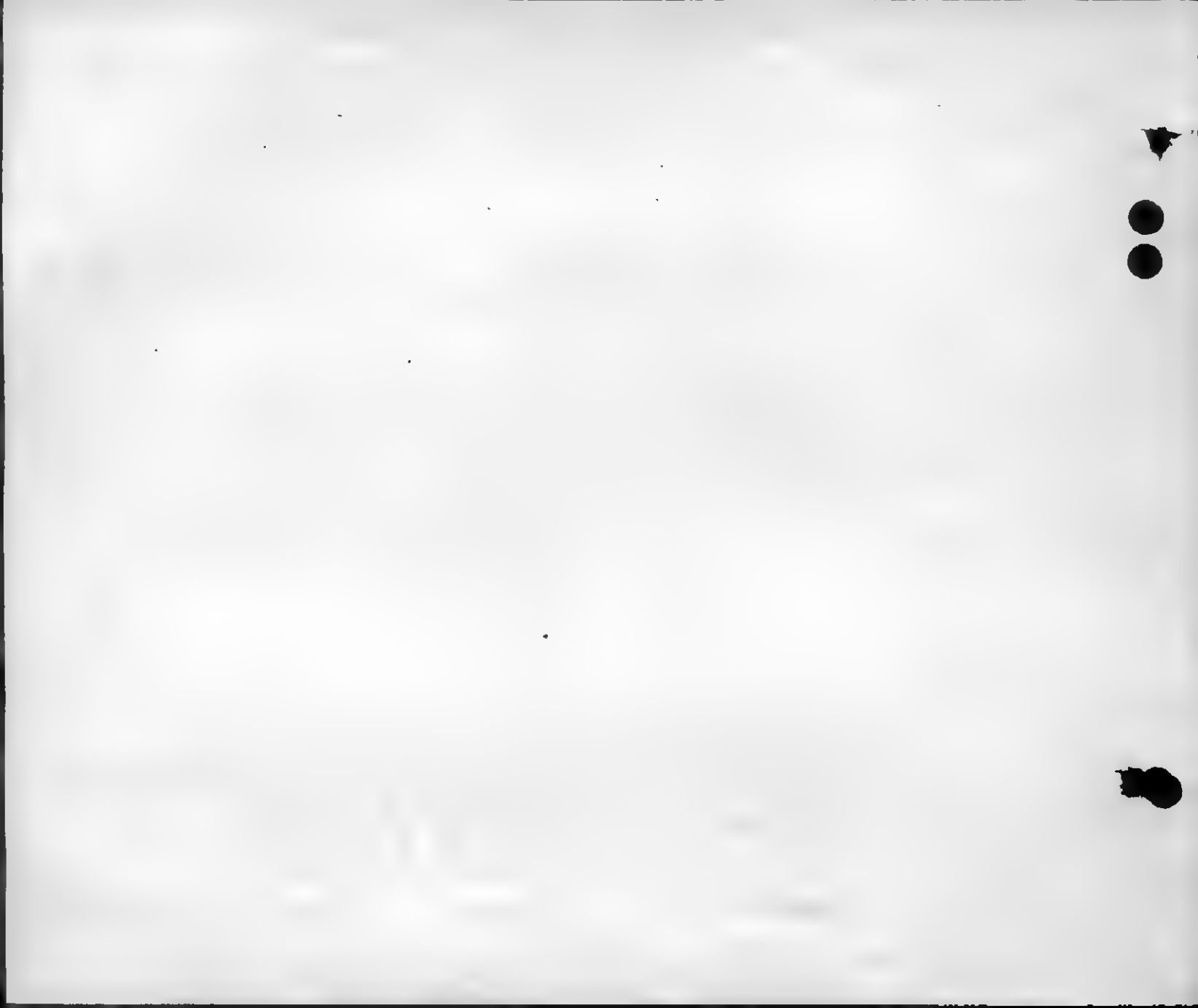
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions: Residence addressed on)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		a. STATE <b>Maryland</b>	
c. LENGTH OF STAY IN b. <b>324 Cedar Lane</b>		b. COUNTY <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Edna Gertrude Pace</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
3. NAME OF DECEASED (Type or print) <b>Female</b>		d. STREET ADDRESS <b>224 "A" Street</b>	
5. SEX <b>Female</b>		4. DATE OF DEATH <b>6 10 1961</b>	
6. COLOR OR RACE <b>White</b>		7. MARried <input type="checkbox"/> NEVER MARried <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10-1-1893</b>		9. AGE (In years last birthday) <b>67</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Ferrest</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Keontz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mrs. Lois Nuse, Rockville, Maryland</b>	
17. INFORMANT <b>Mrs. Lois Nuse, Rockville, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Endometrium</b> 172X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Esophageal Diverticula Hernia</b>	
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>4/24 1961 to 6/10 1961</b>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>4/24 1961</b> to <b>6/10 1961</b> that (I) (we) last saw the deceased alive on <b>6/7 1961</b> and that death occurred at <b>6 AM</b> from the causes and on the date stated above	
22a. SIGNATURE <b>Arthur F. Woodward</b> M.D.		22b. DATE SIGNED <b>6/10/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arthur F. Woodward</b>		22d. ADDRESS <b>Rockville - Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-12-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		23d. LOCATION (City, town or county) (State) <b>Brunswick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brunswick, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 13 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06986

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>4617-42nd. St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose M. Parenteau</u>		4. DATE OF DEATH Month Day Year <u>June 9 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/13/98</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Jefferson Porter</u>		14. MOTHER'S MAIDEN NAME <u>Philomene Emard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-42-1237</u>	
17. INFORMANT <u>Edward W. Parenteau</u>		Address <u>4617-42nd St NW Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 8 1961</u> to <u>June 9 1961</u> , that (I) <del>was</del> last saw the deceased alive on <u>June 9 1961</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Elaine A. Murphy M.D.</u>		22b. DATE SIGNED <u>6-10-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. Murphy</u>		22d. ADDRESS <u>4812 Ellicott St NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 13, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City, town, or county) (State) <u>Ga. Ave. Silver Spring Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Chose Funeral Home Inc D.C.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kinn</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 14 '61</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

7000

06987

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash Va</u> b. COUNTY <u>Clarksburg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>5 Wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				d. STREET ADDRESS <u>4323 PARKILL C COURT</u>			
3. NAME OF DECEASED (Type or print) First <u>Dorsey</u> Middle <u>H.</u> Last <u>PARRILL</u>				4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-75</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY — — — —		11. BIRTHPLACE (State or foreign country) <u>West. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph P. Parrill</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Foley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. —		17. INFORMANT <u>D. H. PARRILL, 2139 WISC. AVE. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Consolidation - fld. ablung - (poss. malign.)</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic ht disease - since Feb.</u> DUE TO (c) <u>Urinary infection assoc. i prostetion</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>2 yrs?</u> <u>5 mos?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> 19 <u>61</u> to <u>6/23</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/22</u> 19 <u>61</u> , and that death occurred at <u>3:44</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Marvin Wadler</u>				22b. DATE SIGNED <u>6/23/61</u>		22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>	
22d. ADDRESS <u>8218 WISCONSIN AV. BETH.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>6-23-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BRIDGEPORT CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CLARKSBURG, W. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph E. Quinn, Inc., 1756 Pa. Ave. NW.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15M 9/60

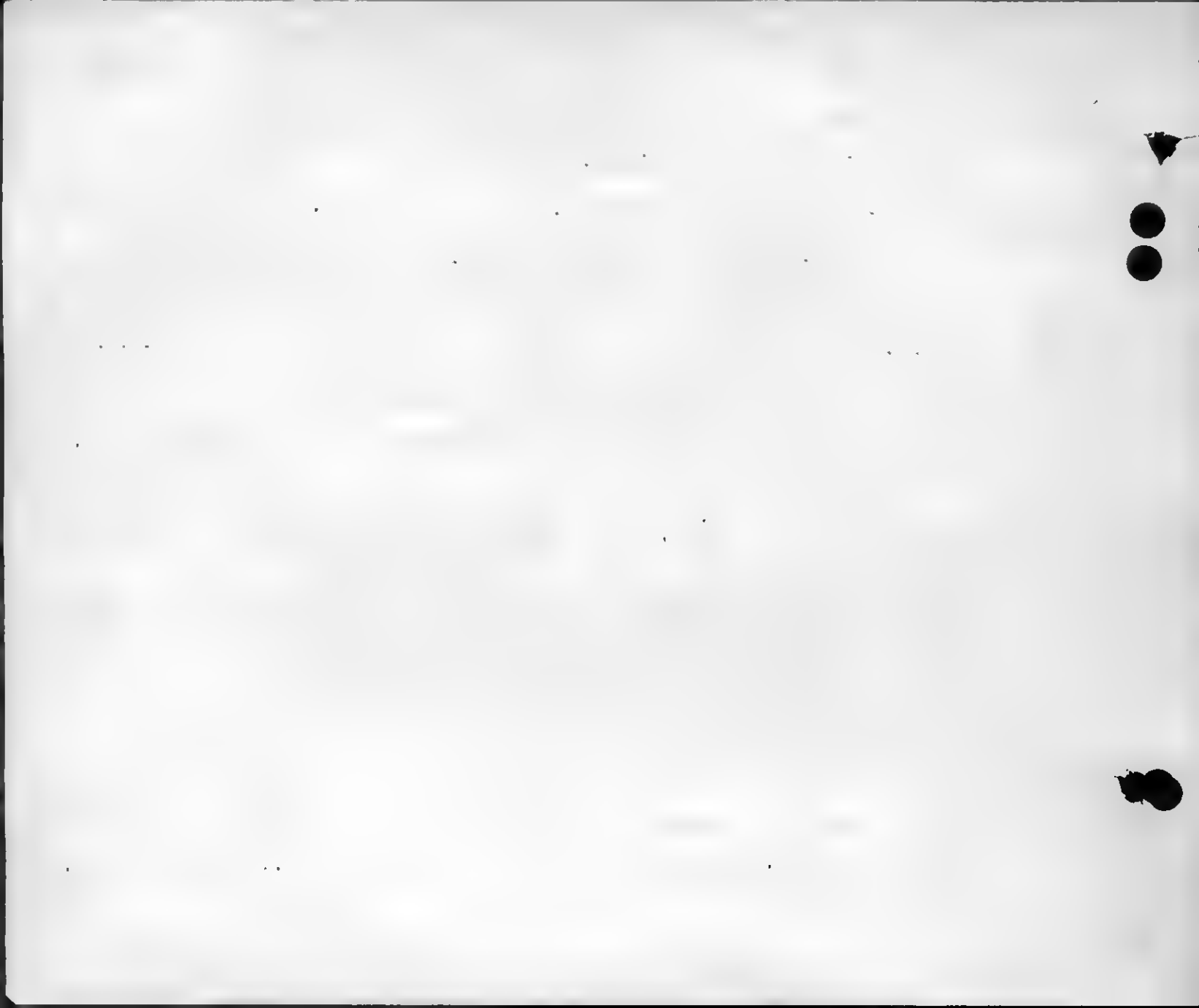
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
700.  
CERTIFICATE OF DEATH

06988

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 'b' d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9804 E. Bexhill Drive</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>9804 E. Bexhill Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>NELL</b> Middle <b>CATHERINE</b> Last <b>PAXTON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 22, 1893</b>	
9. AGE (In years, if under 1 year last birthday) <b>67</b> yrs. <b>7</b> months <b>15</b> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (Country & State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Harrell</b>		14. MOTHER'S MAIDEN NAME <b>Alma Burt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Kent Paxton-Husband-Same Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THROMBOSIS OF BASILAR ARTERY</b> DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>3 HOURS</b> <b>1 YEAR</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1948</b> to <b>JUNE 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>JUNE 7, 1961</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas S. Sappington</b>		22b. DATE SIGNED <b>June 7, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas S. Sappington, M.D.</b>		22d. ADDRESS <b>1025 CONNECTICUT AVE., NW.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>		23b. DATE THEREOF <b>6/8/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>West Point Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Liberty Indiana</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>JUN 9 '61</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kins</b>	







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7003

## CERTIFICATE OF DEATH

Reg. Dist. No. 06990

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4410 Puller Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Adelaide Stagemann PECA</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1873</b>
9. AGE (In years last birthday) <b>87 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>9</b> Days <b>1</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA-Naturalized</b>	
13. FATHER'S NAME <b>John Stagemann</b>		14. MOTHER'S MAIDEN NAME <b>Dorthea VonWerman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Dorothea Armstrong-Daughter-same 2d</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>2867</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Hypoproteinemia, Anemia</b> DUE TO (c) <b>Chronic Dehydration</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b> <b>6-8 mo.</b> <b>2-3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1959</b> to <b>June 2, 1961</b> , that I last saw the deceased alive on <b>June 1, 1961</b> , and that death occurred at <b>3:30 P.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>10609 Concord Street</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> MD		ADDRESS <b>10609 Concord Street</b>	
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>		<b>Kensington, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/5/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 8 '61</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Frank</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7004

06991

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Virginia</b>	
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <b>Williamsburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>5 Bayberry Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas Green</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-10-94</b>	
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Bernard PEYTON</b>		14. MOTHER'S MAIDEN NAME <b>Louise RAMSEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1911 - 1947</b>	
17. INFORMANT <b>(W) Mrs. Mary M. Peyton, same as #2 above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>200-1</b> IMMEDIATE CAUSE (a) <b>Lymphosarcoma, with metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <b>20</b> (this hospital) attended the deceased from <b>May 3, 1961</b> to <b>June 28, 1961</b> , that <b>20</b> (we) last saw the deceased alive on <b>June 28, 1961</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>B. L. Kelley</i>		22b. DATE SIGNED <b>6-29-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. L. KELLEY, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-3-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) _____ (State) _____ <b>Arlington Virginia</b>	
24. ATTENDING DIRECTOR'S SIGNATURE <i>R. A. Humphrey</i>		25a. REC'D BY REGISTRAR <b>JUL 3 '61</b>	
24. ADDRESS <b>R. A. Humphrey Funeral Home, Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Coroner notified and will Approve.

7005

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06992

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>14124 - Aspen St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Floyd J. Porter</u>		4. DATE OF DEATH Month Day Year <u>June 2 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/4/183</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Judge</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Patent Office N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John B. Porter</u>		14. MOTHER'S MAIDEN NAME <u>Elleanor Dana</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Blanche H. Porter</u>		Address <u>14124 Aspen St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>10 yrs</u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Neck of Right Femur.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell at home - injured due to Gen. Arteriosclerosis</u>	
20c. TIME OF INJURY Month. Day, Year <u>May 21 1961</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Cherry Chase Md.</u> (County) <u></u> (State) <u></u>
21. I certify that (1) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>53</u> , to <u>June 2</u> , 19 <u>61</u> , that (2) (we) last saw the deceased alive on <u>June 1</u> , 19 <u>61</u> , and that death occurred at <u>5:45</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John R. Ewan</u>		22b. DATE SIGNED <u>6/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John R. Ewan, MD</u>		22d. ADDRESS <u>1835 Euclid N.W. Washington DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/6/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>John S. Ewan</u>		DATE <u>JUN 8 '61</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G255 6/14/61 1wk

## CERTIFICATE OF DEATH

Reg. Dist. No.

06993

7006

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SANDY SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SANDY SPRING</u>			
c. LENGTH OF STAY IN 1b <u>65 yrs</u>				d. STREET ADDRESS <u>Sandy Spring Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
		<u>MARY Alice Powell</u>		<u>JUNE</u>		<u>3 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 27, 1896</u>	9. AGE (In years last birthday) <u>64 6/8</u> yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland, Montgo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Richard Hill</u>				14. MOTHER'S MAIDEN NAME <u>SARAH JANE POWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>none</u>		INFORMANT <u>SARAH FRANCES POWELL</u>		Address <u>Sandy Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC heart disease</u> DUE TO (c) <u>8 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>53</u> to <u>JUNE</u> , 19 <u>61</u> that I last saw the deceased alive on <u>MAY 31</u> , 19 <u>61</u> , and that death occurred at <u>9:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Sullivan K. Ziegler</u> M.D. <u>C. Iney, Md.</u> <u>JUNE 3, 1961</u>							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/6/61</u>		<u>Ash Memorial.</u>		<u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE	
<u>Robert L. Surwode</u>				<u>Rockville, Md.</u>		<u>JUN 12 '61</u>	
						24b. REGISTRAR'S SIGNATURE	
						<u>William L. Evans</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death.



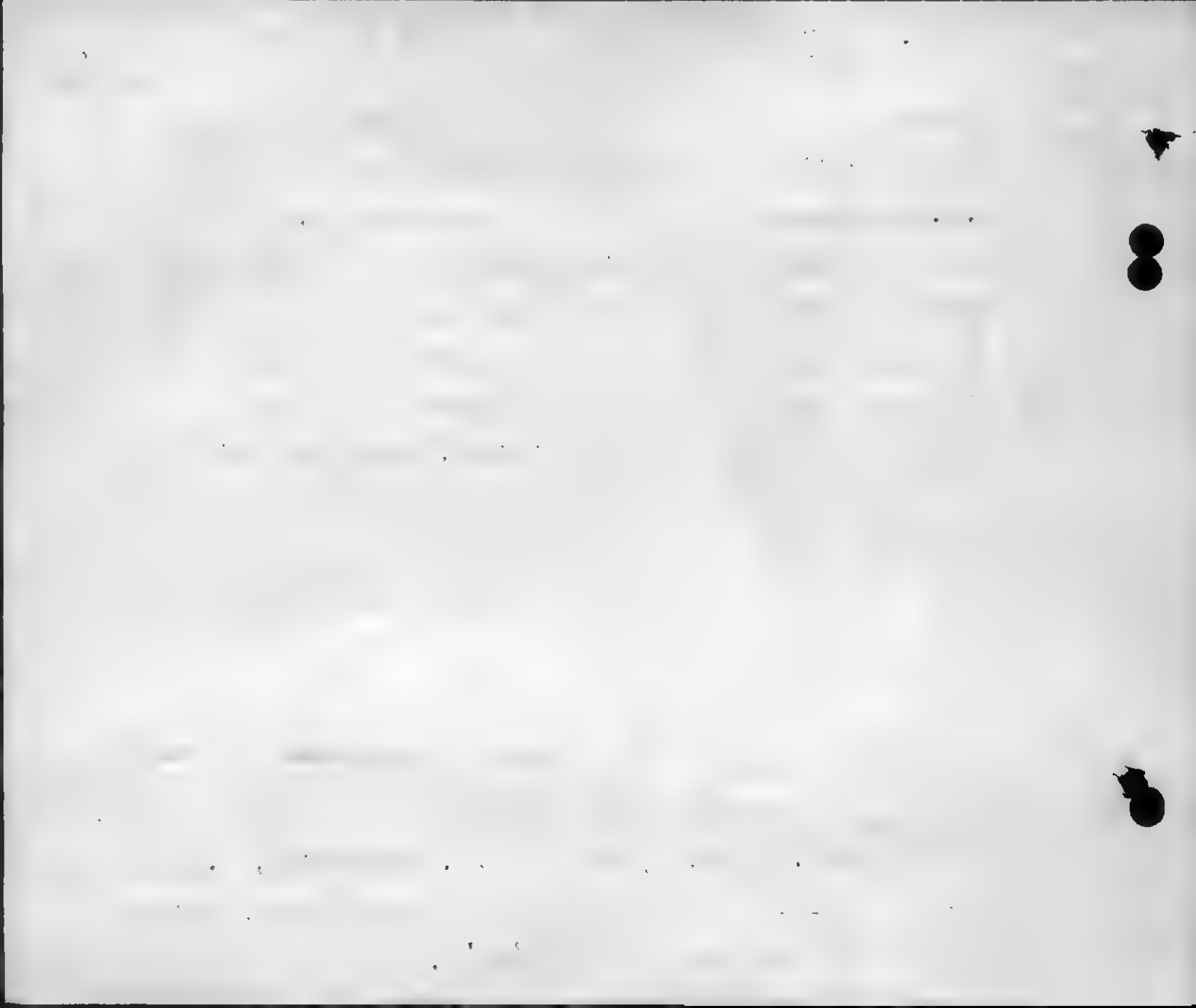
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be filled in by the attending physician and signed by the funeral director. Page 4 of this certificate has been signed by the attending physician and filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/68

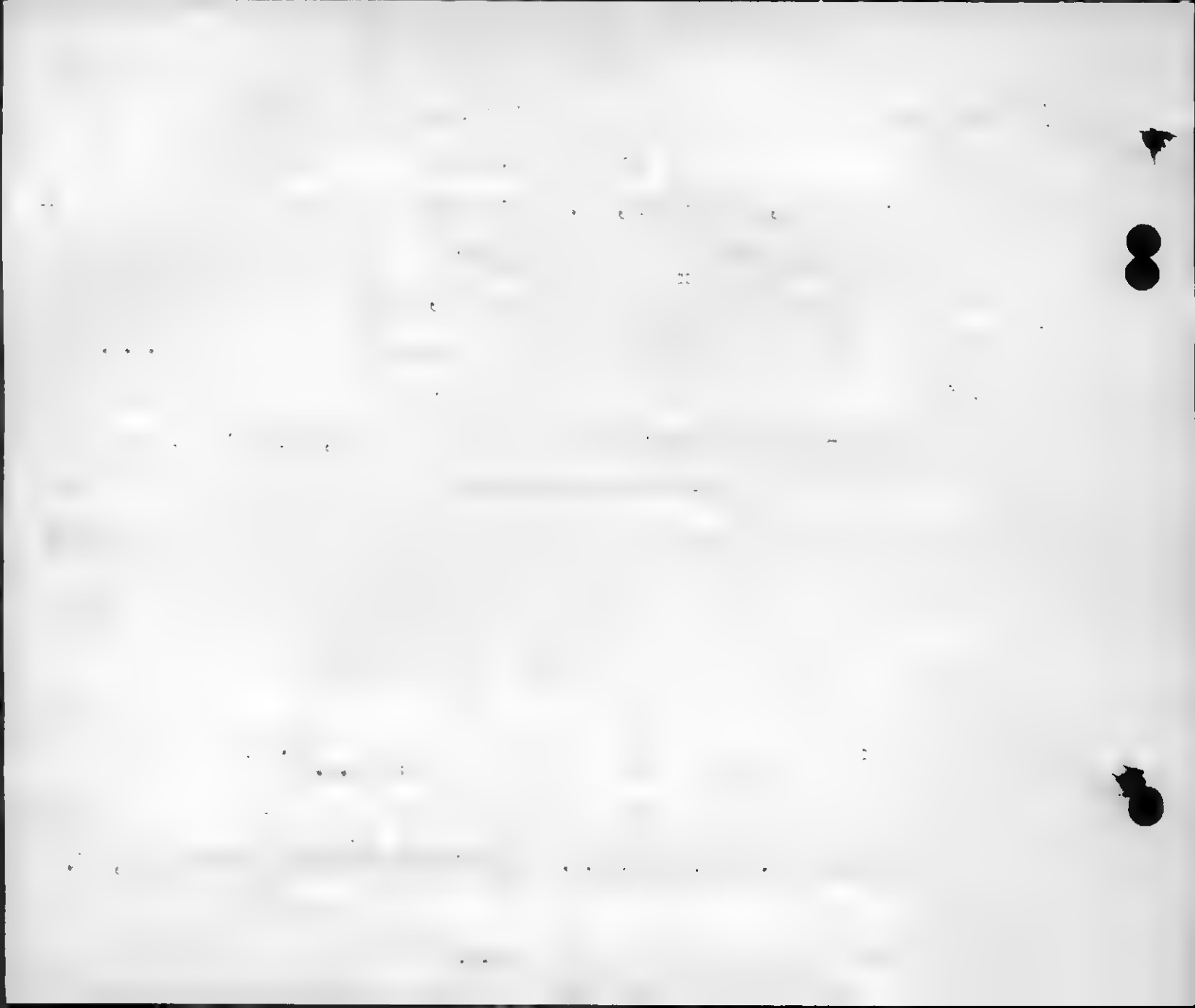
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7007 CERTIFICATE OF DEATH									
06994									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>98</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>14241 Layhill Rd.</u>				
3. NAME OF DECEASED (Type or print) <u>Paul Robert PREPELICA</u>					4. DATE OF DEATH <u>June 10 1961</u>				
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 1 1961</u>					9. AGE (In years last birthday) <u>0</u> <u>10</u> <u>19</u> <u>61</u> IF UNDER 1 YEAR IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Maryland</u>				
13. FATHER'S NAME <u>William John PREPELICA</u>					14. MOTHER'S MAIDEN NAME <u>Delores Maxine COLBERT</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>William J. PREPELICA (Father)</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>776X</u> (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>9 DAYS</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 1 1961</u> to <u>June 10 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 10 1961</u> , and that death occurred at <u>1215AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert V. Rack</u> M.D.					22b. ADDRESS <u>U. S. Naval Hospital, Md.</u>				
22c. PHYSICIAN'S NAME (Type) <u>Robert V. RACK LT, MC, USN</u>					22d. ADDRESS <u>U. S. Naval Hospital, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>6-14-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Virginia</u>		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lydon Wheeler</u> ADDRESS <u>Rockville, Md.</u>					25a. REC'D BY REGISTRAR <u>June 13 '61</u>				
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>									









TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and complies with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complies with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7003

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

C6996

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown (Rural)</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Marylander Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>9628 Acord Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Elizabeth</b> Last <b>Ragan</b>		4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 7, 1879</b>	
9. AGE (In years if UNDER 1 YEAR, if UNDER 24 HRS, last birthday) <b>81 yrs.</b>		10. AGE (In years if UNDER 1 YEAR, if UNDER 24 HRS, last birthday) <b>81 yrs.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dennis McCarthy</b>		14. MOTHER'S MAIDEN NAME <b>Mary O'Brien</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Joseph B. Ragan-son-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pneumonia, Bilateral</b> 425.0 DUE TO Conditions, any, which gave rise to immediate cause (b) <b>Pulmonary Edema, Congestive Hrt. Failure</b> (a), stating the underlying cause last (c) <b>Arteriosclerotic Hypertensive Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>11 days</b> <b>2 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left Hemiplegia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 6, 1961</b> to <b>June 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 19, 1961</b> , and that death occurred at <b>9:01 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Gordon M. Smith</b> 22c. PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>	
22b. DATE SIGNED <b>6/18/61</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Dawsonville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/21/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>		DATE <b>JUN 21 '61</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

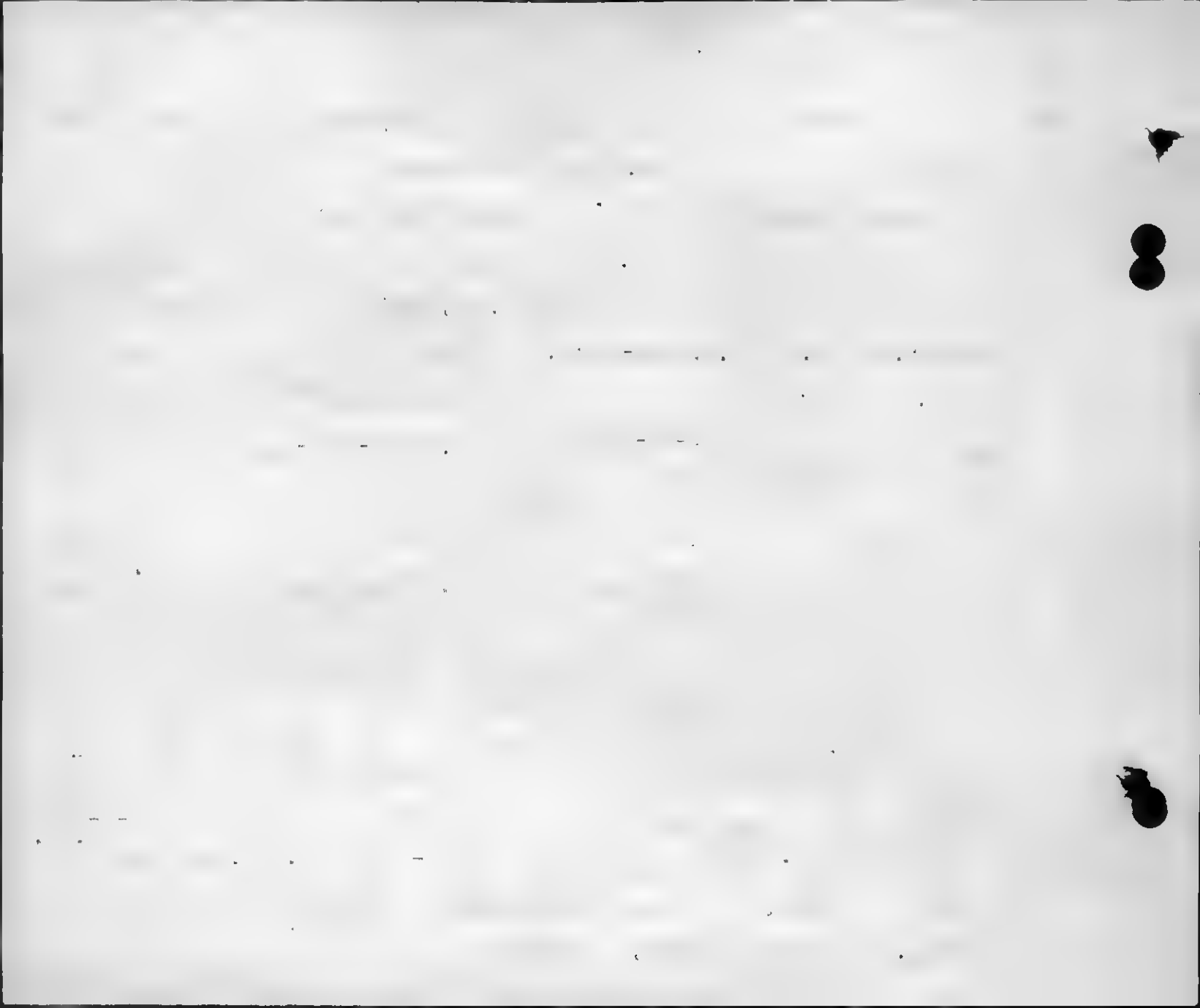
7010

66997

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>1 mo. 5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3000 Mc Comas Ave. Kensington Gardens</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>10608 Nash Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FREDERICK V. RAND</b>		4. DATE OF DEATH <b>June 6, 1961</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mch. 16, 1883</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>20</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Vermont</b>	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Bact. &amp; Path.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt-Agric.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rev. Wilbur Rand</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Miller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>263-46-4843A</b>		17. INFORMANT <b>Louva H. Rand-wife-Same as Item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia -</b> DUE TO (b) <b>Cerebral Thrombosis -</b> DUE TO (c) <b>Cerebral Arteriosclerosis -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>21 days</b> <b>7 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
25a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		25b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)			
26a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		26b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		26c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
26d. (City or town)		26e. (County)		26f. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1961</b> to <b>June 6, 1961</b> , that (I) <b>did</b> see the deceased alive on <b>June 6, 1961</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Neil P. Campbell</b>		22b. DATE SIGNED <b>6-6-61</b>		22c. PHYSICIAN'S NAME (Type) <b>NEIL P. CAMPBELL</b>	
22d. ADDRESS <b>3060 - 16th St., N. W., Washington</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>6/7/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	
23d. LOCATION (City, town or county) <b>Prince Georges Maryland</b>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24b. ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUN 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>					

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60









FOR STATE  
HEALTH DEPT.

(M)

(I)

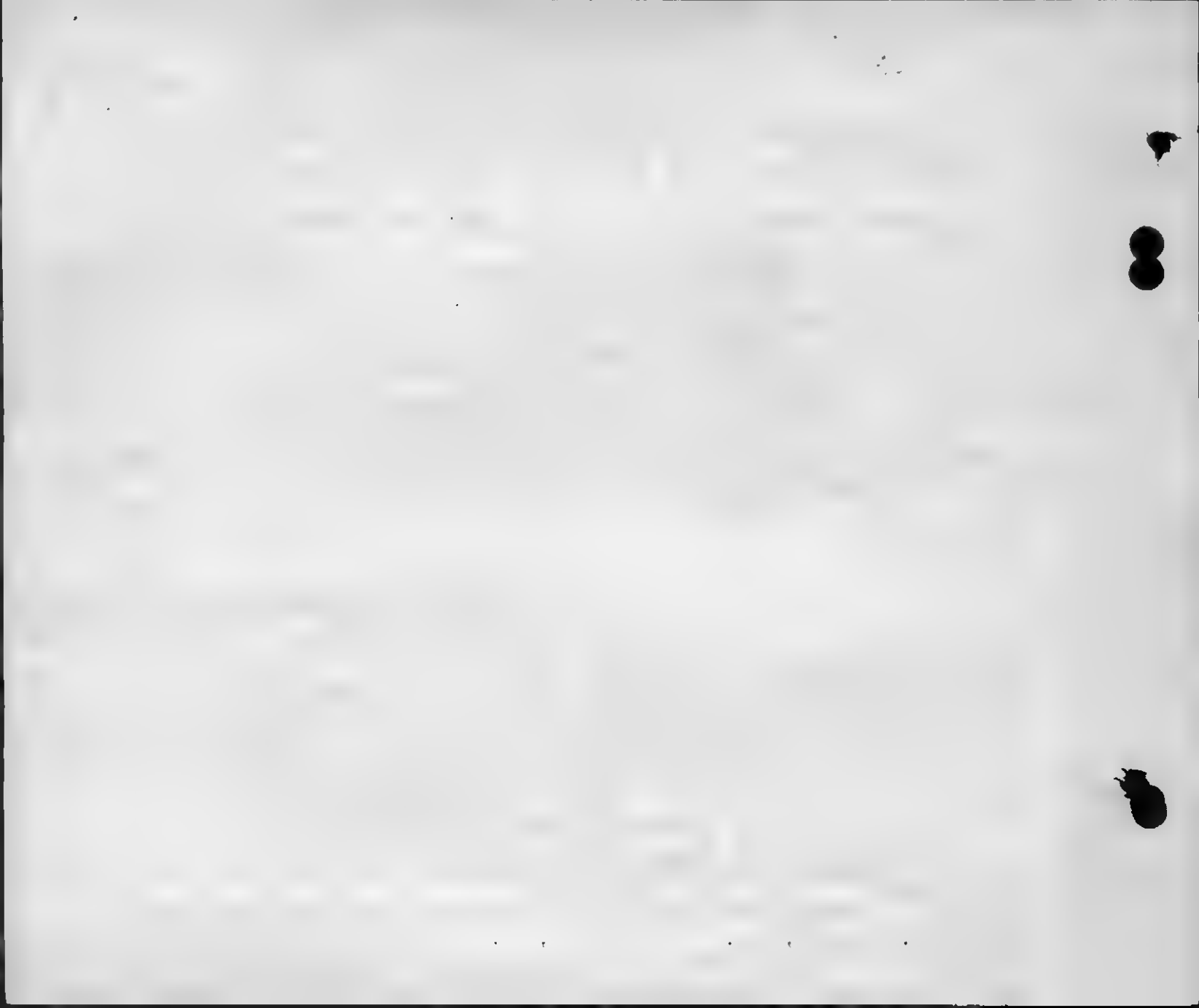
VS. A15ME  
SM 9 60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06999

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN TB <u>6 yrs</u>		d. STREET ADDRESS <u>1800 Hollywood Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>800 Hollywood Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <u>Kimeth Donald Rankin</u> (Type or print)		4. DATE OF DEATH <u>June 22 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk (Mail)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>DC Post Office</u>	9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>22</u> Days <u>22</u> IF UNDER 24 HRS. Hours <u>22</u> Min. <u>22</u>	
11. BIRTHPLACE (State or foreign country) <u>R. I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bright Rankin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Erskins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>117-07-1502</u>	
17. INFORMANT <u>Clara Rankin (wif.)</u>		Address <u>Shen 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>720.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>720.1</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Dr. died in bed</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
BURIAL <u>JUNE 24, 1961 MAYFLOWER HILL CEMETERY TAUNTON, MASSACHUSETTS</u>		DATE <u>6-22-61</u>	
23. FUNERAL DIRECTOR <u>WAGNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>	
24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>		DATE <u>JUN 27 '61</u>	

VS. A15ME  
SM 9 60



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

VR A15 (4)  
15M 9/59

7013

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07000

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>9415 11 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>				d. STREET ADDRESS <u>4930 Butterworth Pl. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Rheinbold</u> Last <u>Rheinbold</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1869</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Deinger</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Frederick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Washington DC</u> <u>Mrs. Lydia Mosley 2240 Hall Pl. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 17, 1961</u> to <u>June 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 30, 1961</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert B. Havell</u>		M.D. <u>  </u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 15, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert B. Havell, MD.</u>		22d. ADDRESS <u>5516 Neb. Ave. DC</u>					
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hine Co.</u>		ADDRESS <u>2901-12 St. N.W.</u>		25a. REC'D BY REGISTRAR <u>DC</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

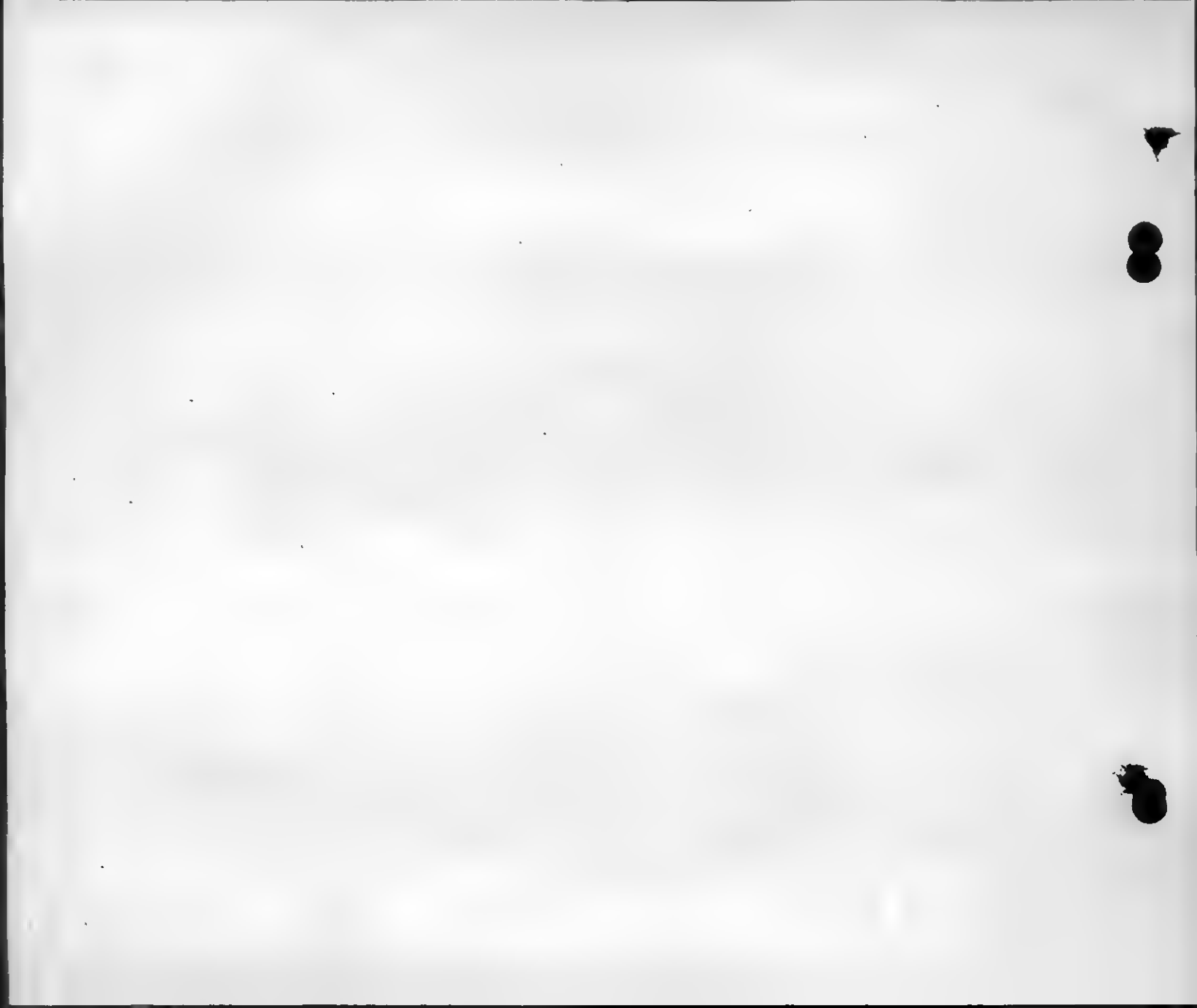
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MEDICAL CERTIFICATION

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18



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

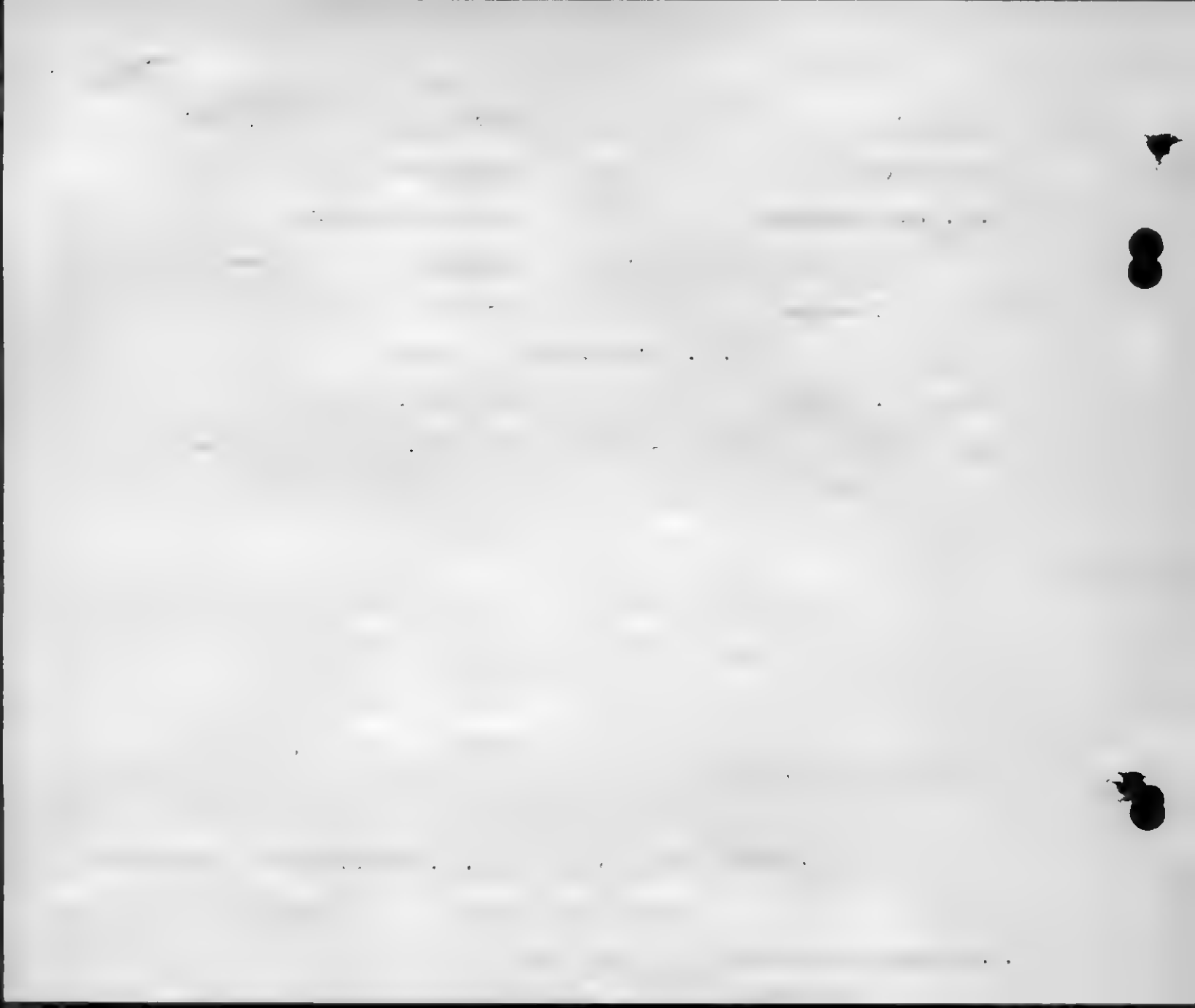
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7014

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07001

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>29 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>3904 Cavendish Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Oscar RISINGER</b>		4. DATE OF DEATH <b>June 14 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-27-26</b>	
9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>35</b> yrs. Months Days Hours Min.		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Marine Corps</b>	
11. BIRTH-PLACE (County & State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William O. RISINGER</b>		14. MOTHER'S MAIDEN NAME <b>Mary Eula NICHOLS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO., <b>1942-1961 463-26-0848</b>	
17. INFORMANT <b>(W) Mrs. Ann C. Risinger, same as #2 above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>circulatory system - infarcted</b> <b>myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 16 1961</b> to <b>June 14 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 14 1961</b> , and that death occurred at <b>6P.M.</b> from the causes and on the data stated above.			
22a. SIGNATURE <b>Larry J. Hines</b>		22b. DATE SIGNED <b>6-15-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Larry J. HINES, CDR, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-20-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co., 1400 Chapin St., NW, WashDC</b>		25a. REC'D BY REGISTRAR <b>JUN 19 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

7015 07002

1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN 1b 31 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland  
b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville  
d. STREET ADDRESS 213 Ritchie Parkway  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒  
f. DATE OF DEATH June 1 1961

3. NAME OF DECEASED (Type or print) Oswald J. Roccati  
First Middle Last  
4. DATE OF DEATH June 1 1961  
Month Day Year

5. SEX Male  
6. COLOR OR RACE White  
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH May 2 1879  
9. AGE (In years last birthday) 82 yrs.  
IF UNDER 1 YEAR: Months Days Hours Mins.  
IF UNDER 24 HRS.: Months Days Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired  
10b. KIND OF BUSINESS OR INDUSTRY Cook  
11. BIRTHPLACE (County & State, or foreign country) Turin, Italy  
12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME Unknown  
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)  
16. SOCIAL SECURITY NO. 578-05-1976  
17. INFORMANT Arnold Roccati (son) Address Same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Confluent bronchopneumonia  
441X DUE TO (b) \_\_\_\_\_  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) \_\_\_\_\_  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).  
Prostatic carcinoma, congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐  
INTERVAL BETWEEN ONSET AND DEATH \_\_\_\_\_

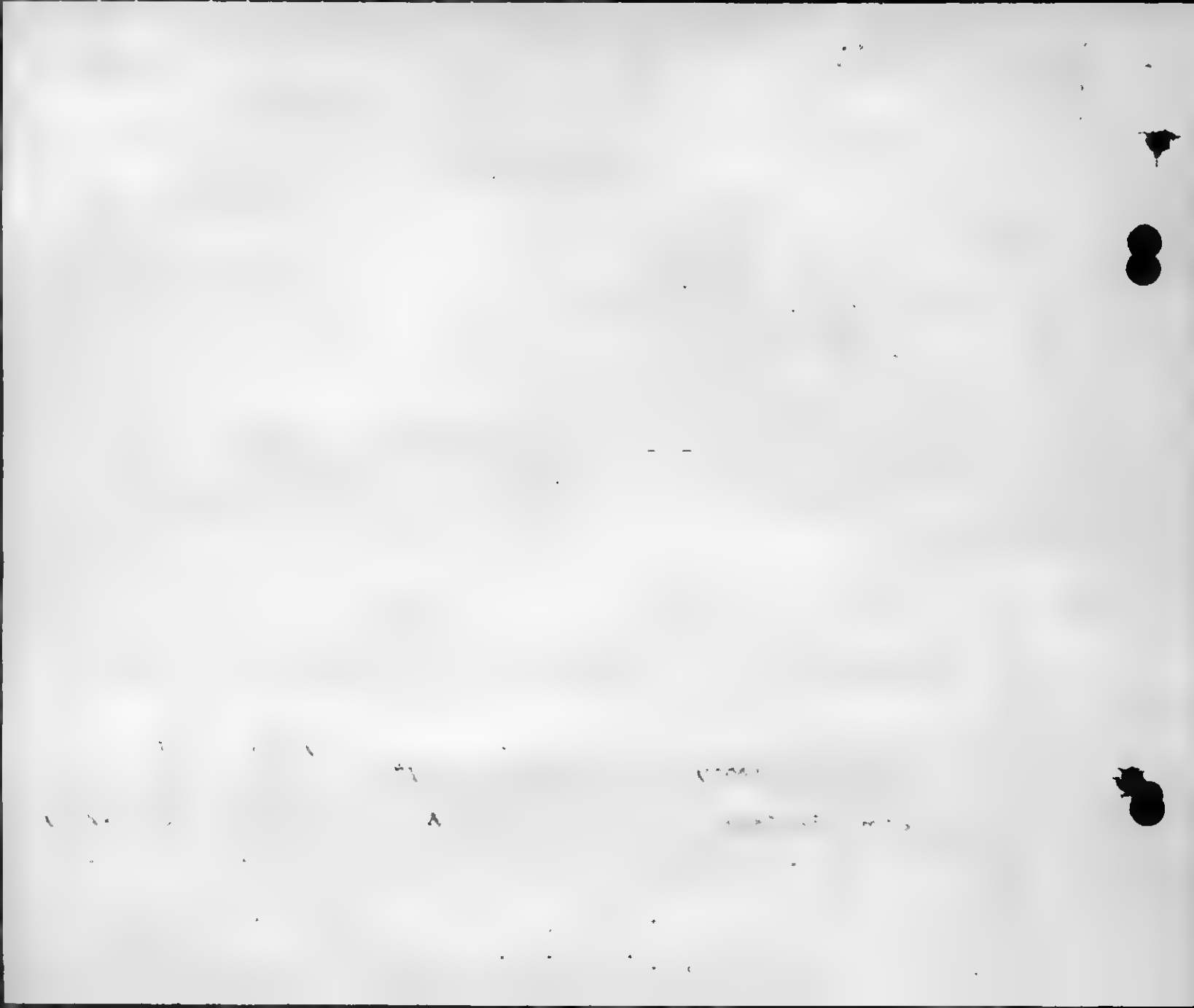
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1950 to June 1961, that (I) (we) last saw the deceased alive on 31 May 1961, and that death occurred at 4:40 PM, from the causes and on the date stated above.

22a. SIGNATURE John G. Ball  
22b. DATE SIGNED 2 June 1961  
22c. PHYSICIAN'S NAME (Type) John G. Ball  
22d. ADDRESS 7936 Old Georgetown Rd., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  
23b. DATE THEREOF 6/5/61  
23c. NAME OF CEMETERY OR CREMATORY St. Marys  
23d. LOCATION (City, town or county) (State) Rockville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS Funeral Home-1331 E. Montg. Ave. Rockville, Md.  
25a. REC'D BY REGISTRAR JUN 5 1961  
25b. REGISTRAR'S SIGNATURE William S. Hines  
DATE





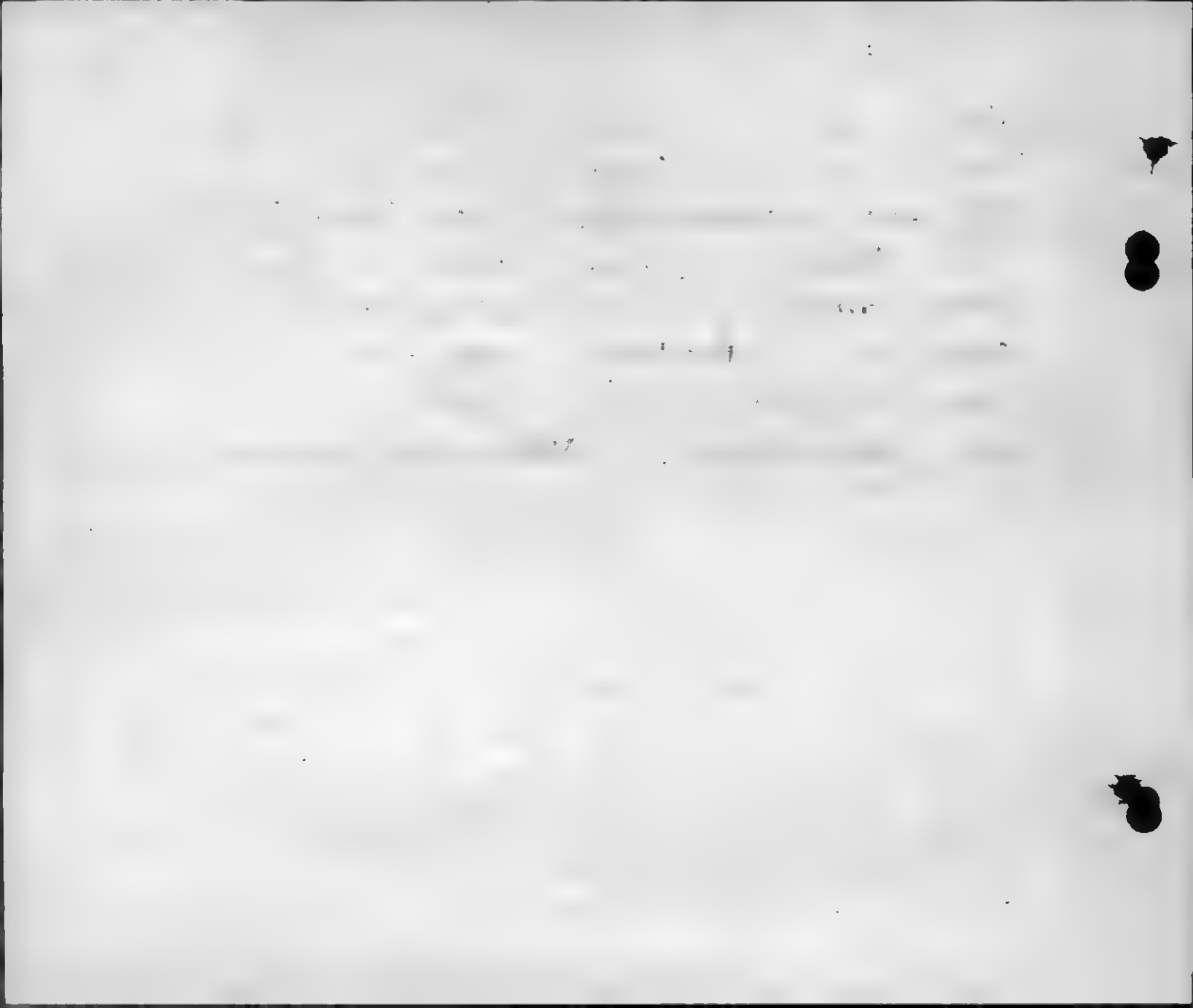
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FOR STATE  
HEALTH DEPT.

7015  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07003

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11305 Clover Hill Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF (Type or print) <u>Norman</u> First <u>N.M.N.</u> Middle <u>Rosner</u> Last			4. DATE OF DEATH <u>June</u> Month <u>11</u> Day <u>1961</u> Year		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>August 24, 1914</u>		9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		13. BIRTHPLACE (State or foreign country) <u>New York</u>	
14. FATHER'S NAME <u>Morris Rosner (DEC)</u>		15. MOTHER'S MAIDEN NAME <u>Sarah KLEIN (DEC)</u>		16. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW2 Army</u>			18. SOCIAL SECURITY NO. <u>055-10-7740</u>		
19. INFORMANT <u>Washington Sanitarium and Hospital</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain stem compression</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebral laceration + hemorrhage</u> (c) <u>Bullet wound thru rt temple</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a):					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Self-inflicted bullet wound thru rt temple</u>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound thru rt temple</u>		20c. TIME OF INJURY Month, Day, Year <u>2:30 p.m. 6-9 1961</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>			
20f. (City or town) <u>Silver Spring</u>		20g. (County) <u>Montgomery</u>		20h. (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>			DATE SIGNED <u>6-11-61</u>		
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>6/14/61</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>ARL. NAT'L. Cem</u>			22d. LOCATION (City, town, or country) <u>ARL. VA.</u>		
23. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>			24a. REC'D BY REGISTRAR <u>JUN 13 '61</u>		
ADDRESS <u>4217 E. 20th St</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Fries</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

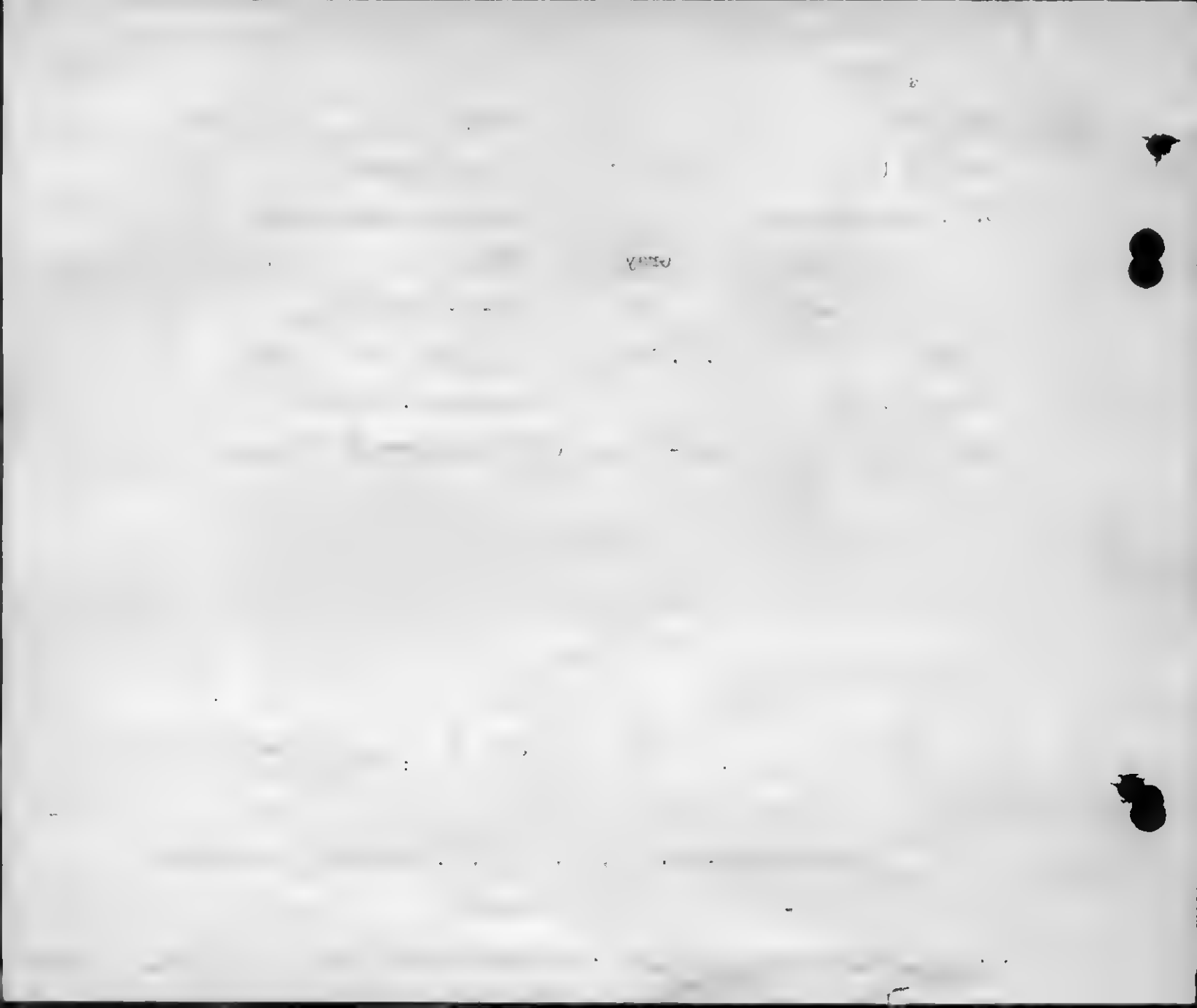


## 07004

2017

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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

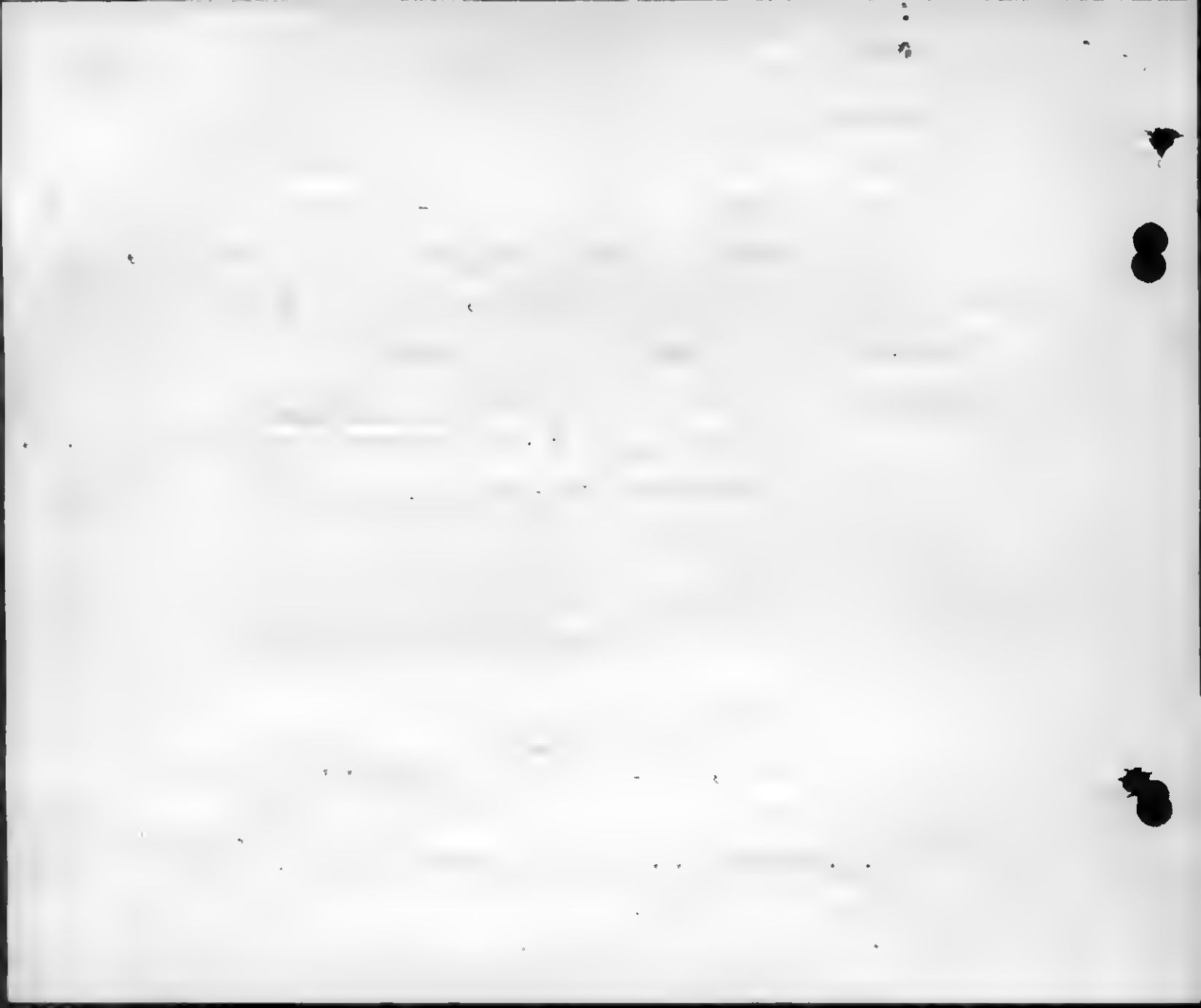
CERTIFICATE OF DEATH

7018

Item 9 from 0288 6/12/61 ink

07005

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ozone Park, Long Island</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		d. STREET ADDRESS <b>10717-88th Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Rose</b> Last <b>Ruggieri</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1900</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Carmelo Marotta</b>		14. MOTHER'S MAIDEN NAME <b>Angelina Ruggieri</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>National Institutes of Health, Bethesda 14, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>205X Mycosis Fungoides; with Congestive Heart Failure</b> DUE TO (b) <b>205X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 years 3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 19 61</b> to <b>June 1, 19 61</b> that (I) (we) last saw the deceased alive on <b>June 1, 19 61</b> and that death occurred at <b>2:58 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>R. B. SCOGGINS, M.D.</b>		22b. DATE SIGNED <b>6/2/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. B. SCOGGINS, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 6-2-61</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Long Island, New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 8 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>William S. Flann</b>	



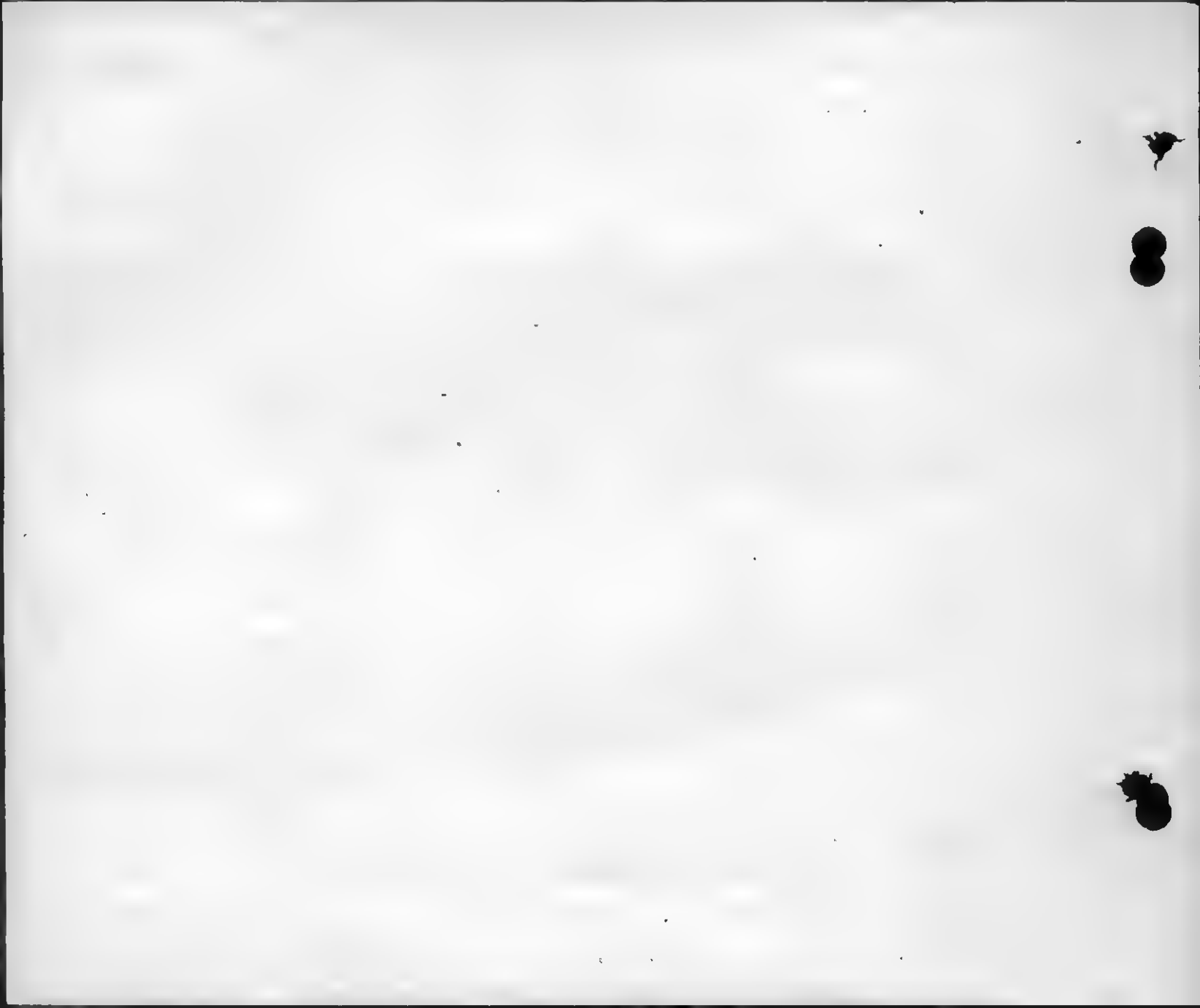
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7013

07006

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9701 Stoneham Terrace</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elmhurst</b>	
		f. STREET ADDRESS <b>51-15 Van Kleeck Street</b>	
3. NAME OF DECEASED (Type or print) <b>Therese</b> First Middle Last <b>Schanzer</b>		4. DATE OF DEATH <b>June 9 1961</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-14-1899</b>
9. AGE (In yrs last birth) <b>61</b> yrs		10. IF UNDER 1 YEAR: Months <b>11</b> Days <b>25</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hat Designer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>Naturalized</b>	
13. FATHER'S NAME <b>Landau</b>		14. MOTHER'S MAIDEN NAME <b>Beatrice</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Husband</b> Address <b>Same as Item #2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer, intestinal</b> 153.9 DUE TO (b) <b>his large duodenal ulcer unknown to me</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(Empyema of lung MD 225 West 86th St N.Y.C.)</b> <b>(had been physician until 5/29/61.)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>May 29 1961</b> to <b>June 5 1961</b> , that (I) (we) last saw the deceased alive on <b>6/5 1961</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above	
22a. SIGNATURE <b>Allen J. Null</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Allen J. Null MD</b>		22d. ADDRESS <b>8601 Old Georgetown Rd, Bethesda</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>6/12/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Georges Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Rumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUN 12 '61</b> DATED <b>JUN 12 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Wm. L. Thomas</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
 Dr John Ball notified and approved given for my signature to the State Board of Health.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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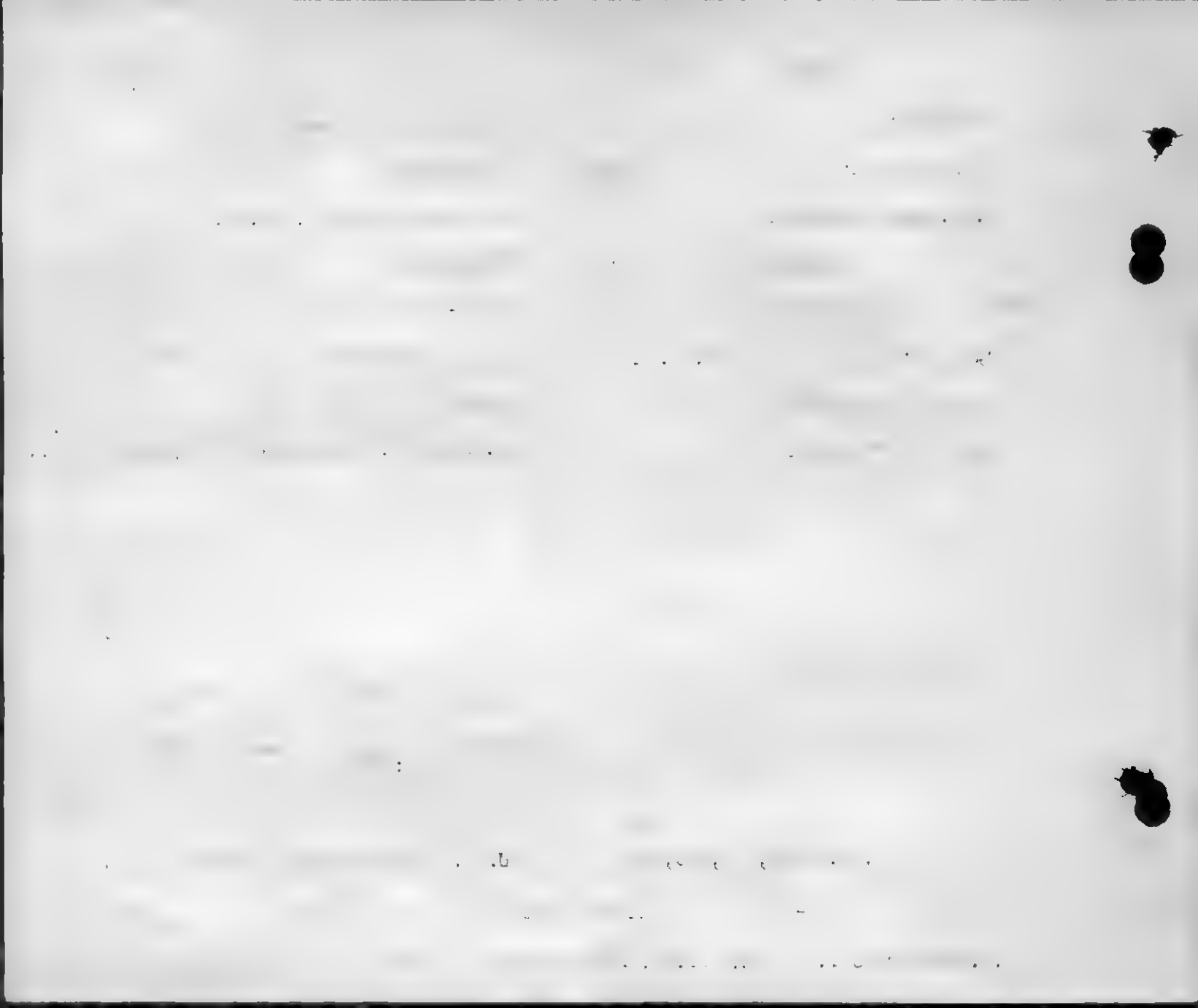
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07009

23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>22 June 61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
24. FLNERA - DIRECTOR'S SIGNATURE <i>Cunningham Funeral Home Inc.</i> <b>Cunningham Funeral Home Inc.</b>		ADDRESS <b>Box 65, Alex., Va.</b>	25a. REC'D BY REGISTRAR DATE <b>JUN 22 '61</b>
		25b. REGISTRAR'S SIGNATURE <i>(Signature)</i>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH  
1 MONTHS

[illegible]

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	YES	<input checked="" type="checkbox"/>	NO	<input type="checkbox"/>
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*(continued)*

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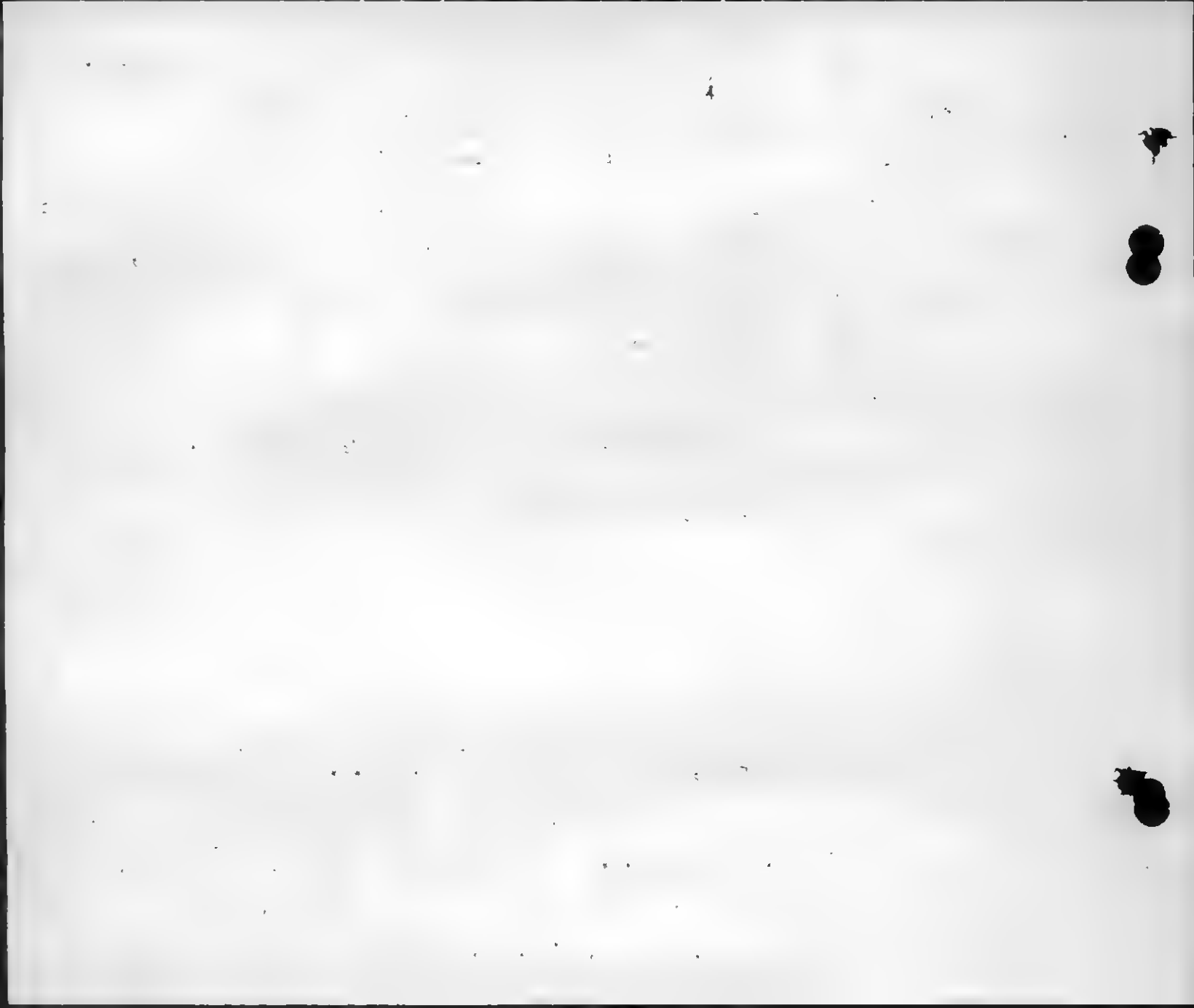
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## 07003

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07010**

7023

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Rensselaer</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Green Acres</b>			c. LENGTH OF STAY IN 1b <b>2 weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Schenectady</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5319 Wakefield Road</b>				d. STREET ADDRESS <b>36 Swan Street</b>			
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>H.</b> Last <b>SCOTT</b>				4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 29 1882</b>		9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>16</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nowell Scott</b>				14. MOTHER'S MAIDEN NAME <b>Clara Hynds</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes Unknown</b>		17. INFORMANT <b>Leo Scott-Son-same as 1d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Hypertension</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetic mellitus</b> <b>6 years</b>							19. WAS AUTOPSY PERFORMED? <b>NO</b> <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/15/61</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify), <b>Bur-Transit</b>		22b. DATE THEREOF <b>6/20/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bramanville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bramanville, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 19 '61</b>	
				24b. REGISTRAR'S SIGNATURE <i>William J. K...</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Examiner. Page 4 should be forwarded to the Office of Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

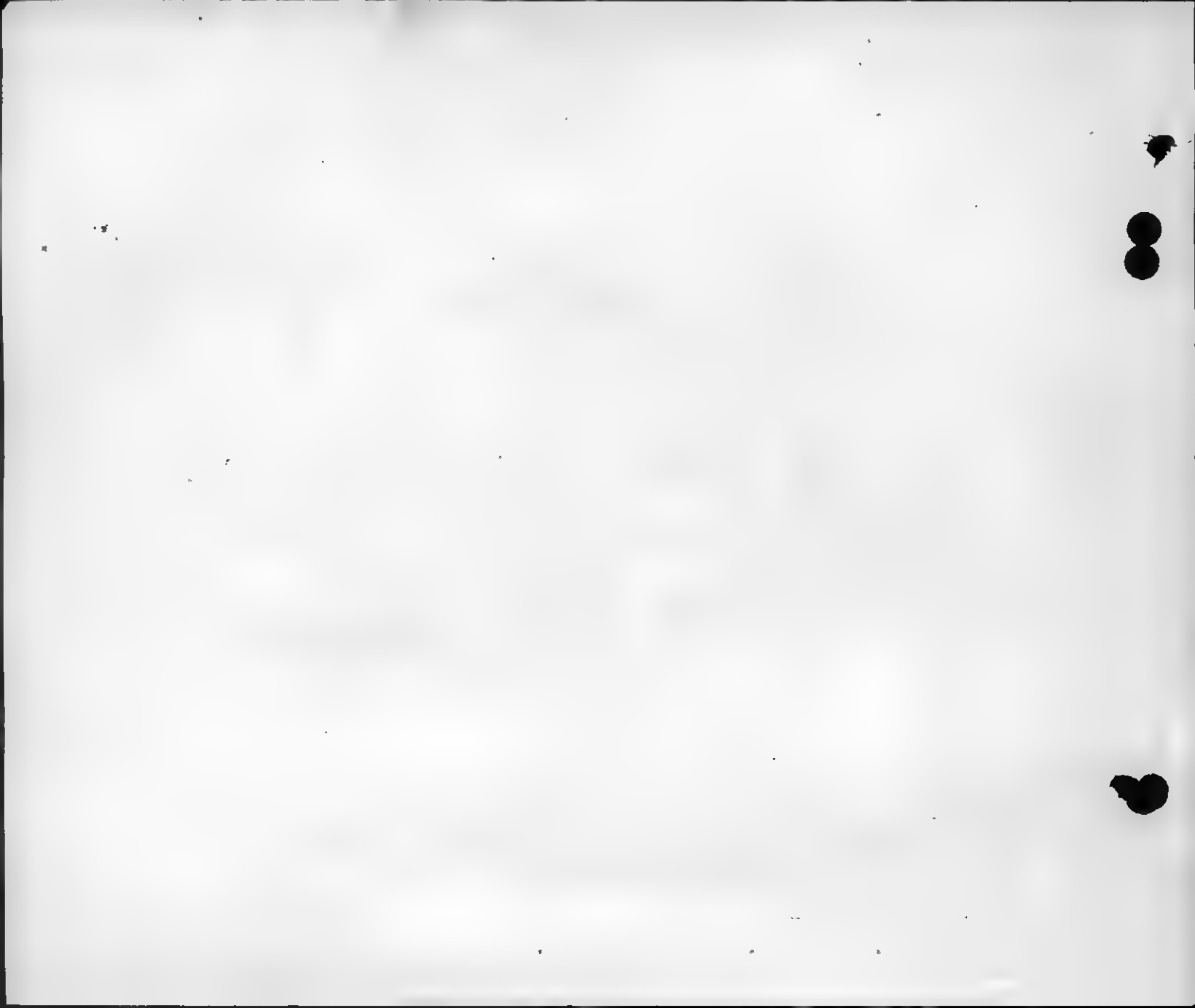
7024

Item 9 Film 0248 5/9/61 mh

07011

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington Grove</b> d. STREET ADDRESS <b>Brown Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Wall</b> Last <b>Seaton</b>		4. DATE OF DEATH Month <b>6</b> Day <b>4</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/1/1880</b>
9. AGE (In years last birthday) <b>81 80</b> rs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HH</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Andrew Wall</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> 122.2 DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 29 1961</b> to <b>June 4 1961</b> , that (I) (we) last saw the deceased alive on <b>June 4 1961</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Luciano L. Leal</b> M.D.		22b. DATE SIGNED <b>June 4, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Luciano L. Leal</b>		22d. ADDRESS <b>Gaithersburg Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation 6-7-61</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town, or county) (State) <b>Mladensburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner.</b>		25a. REC'D BY REGISTRAR <b>Gaithersburg Md.</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>JUN 7 '61</b>	

TO HOSPITAL OR A DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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<div style="display: flex; justify-content: space-between;"> <div> <p>7025</p> </div> <div> <p>7025</p> </div> <div> <p>07012</p> </div> </div> <div style="text-align: center;"> <p><b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b></p> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN IS <u>47 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>12101 Porttree Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Petrina August</u> First Middle Last <b>4. DATE OF DEATH</b> <u>June 16 1961</u> Month Day Year				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>6-28-04</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				<b>9. AGE</b> (In years last birthday) <u>56</u> IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Minnesota</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Hallgrimur GOTTSKALKSON</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Ingbjorg FOSS</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>(S) Lt. K. W. Sell, MC, USN, same as #2 above</u> Address <u>  </u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Breast &amp; Metastases</u> DUE TO <u>110X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>  </u> Hour a.m. <u>  </u> p.m. <u>  </u> <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>				<b>21. I certify that</b> <u>  </u> (this hospital) attended the deceased from <u>April 30, 1961</u> to <u>June 16, 1961</u> , that <u>  </u> (we) last saw the deceased alive on <u>June 16, 1961</u> , and that death occurred at <u>10:07AM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>W. D. Hooper</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>W. D. HOOVER, LT, MC, USN</u>				<b>22b. DATE SIGNED</b> <u>6-16-61</u> <b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>				<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>6-19-61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rockville Cemetery</u> <b>23d. LOCATION (City, town or county)</b> <u>Rockville</u> <b>(State)</b> <u>Maryland</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler</u> <b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u> <b>DATE</b> <u>JUN 21 '61</u>				<b>25c. NAME OF CEMETERY OR CREMATORY</b> <u>Rockville Cemetery</u> <b>25d. LOCATION (City, town or county)</b> <u>Rockville</u> <b>(State)</b> <u>Maryland</u>				<b>25e. REC'D BY REGISTRAR</b> <u>  </u> <b>25f. REGISTRAR'S SIGNATURE</b> <u>  </u> <b>DATE</b> <u>JUN 21 '61</u>			

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TO HOSPITAL OR A FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death.

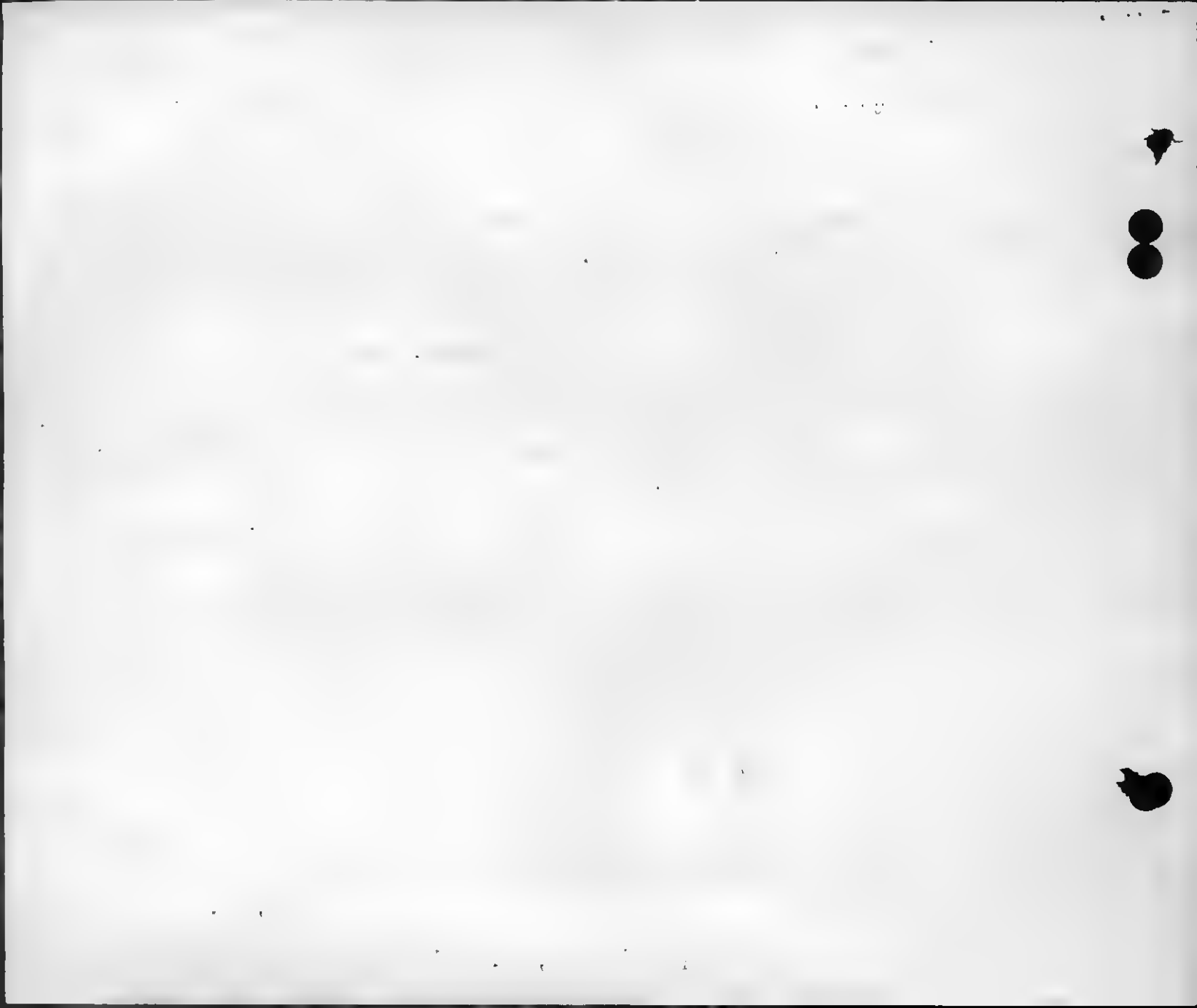
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7026

07013

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>11</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				d. STREET ADDRESS <b>5917 - LeMay Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hilda</b> Middle <b>L.</b> Last <b>Shafer</b>				4. DATE OF DEATH Month <b>6</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/30/21</b>	
9. AGE (In years last birthday) <b>40</b> yrs		IF UNDER 1 YEAR Months <b>4</b> Days <b>14</b>		IF UNDER 24 HRS Hours <b>14</b> Min. <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Taunton, Mass.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>George Jones</b>				14. MOTHER'S MAIDEN NAME <b>Hilda Hathaway</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>215-18-0054</b>		17. INFORMANT <b>Miss Janice Jones</b> Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Edema</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, breast - Metastases</b> DUE TO lying cause last. (c) <b>1.8 m</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 w</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from <b>3/31</b> 19 <b>61</b> , to <b>6/14</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6/14</b> 19 <b>61</b> , and that death occurred at <b>3:25 P.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>J. N. TUCHY, M.D.</b>				22b. ADDRESS <b>7720 WISCONSIN AVE BETHESDA 14, MD.</b>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	
23d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>				25a. REC'D BY REGISTRAR <b>1331 E. Montgomery Ave Rockville, Md.</b>		25b. REG-STRAR'S SIGNATURE <b>James S. Thomas</b>	
25c. DATE <b>JUN 19 61</b>							



12  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07014

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address) <u>United States Hospital</u>		d. STREET ADDRESS <u>823 14th Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Bertha Feffer Shantz</u>		4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1894</u>
9. AGE (In years last birthday) <u>67</u> yrs.	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u>	11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>PHILLIP</u>		14. MOTHER'S MAIDEN NAME <u>FEFFER UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MR. IRVING SHANTZ - SON</u>		Address <u>SON</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (c) <u>hypertension</u> DUE TO (e), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-16-61</u>	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county)		Address (Street, city, town or county)	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/18/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION</u>		22d. LOCATION (City, town, or county) (State) <u>MARYLAND</u>	
23. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		24a. REC'D BY REGISTRAR <u>4217</u>	
ADDRESS <u>4217</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
DATE <u>JUN 19 '61</u>		DATE <u>JUN 19 '61</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

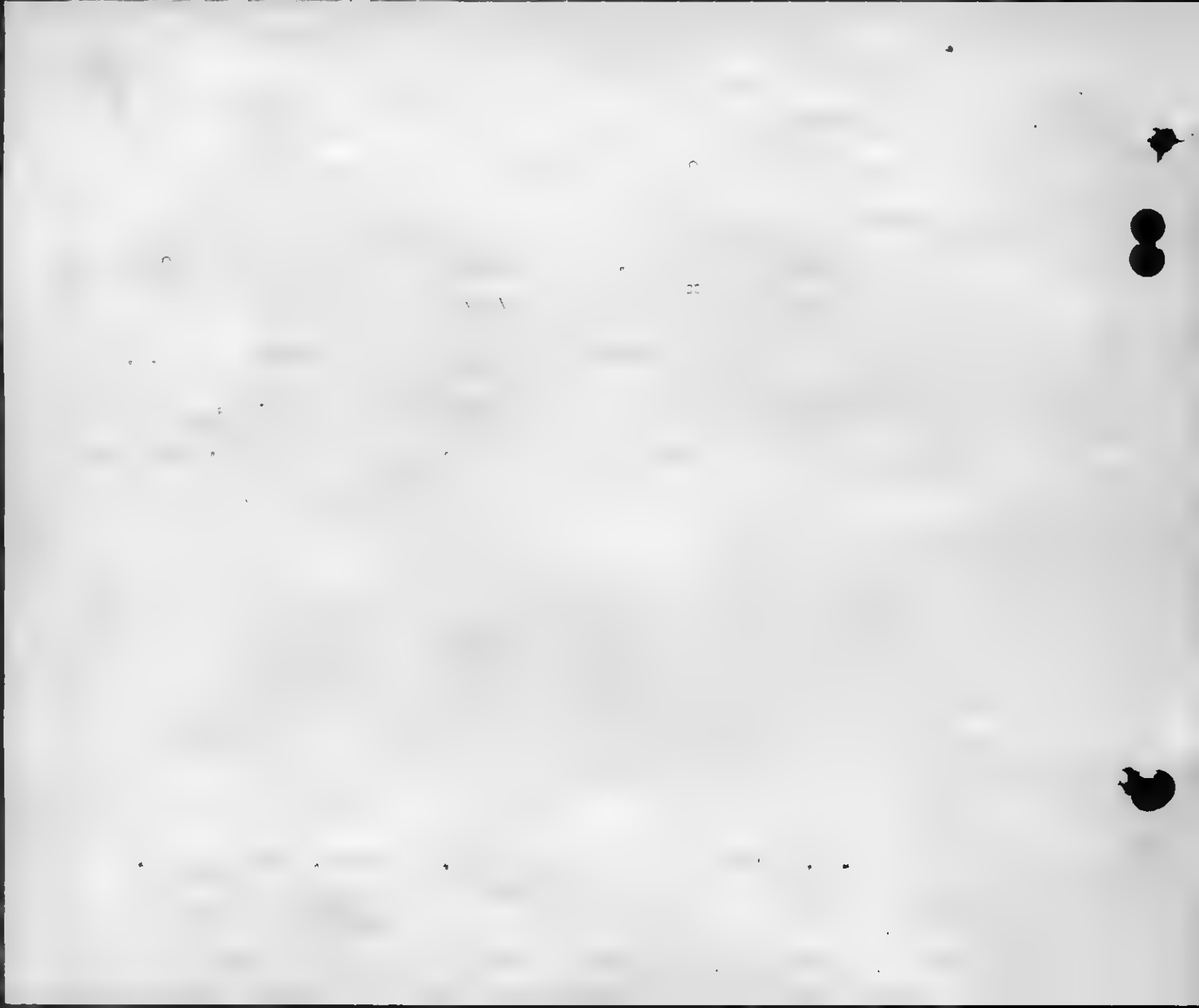
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7028

07015

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN TB <b>2 DAYS 8 HOURS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b> d. STREET ADDRESS <b>615 W. Montgomery, Rockville, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LILLIAN R. SHIPLEY</b>				4. DATE OF DEATH Month Day Year <b>JUNE 22 19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/27/86</b>	
9. AGE (In years last birthday) <b>74 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (County & State or foreign country) <b>MARION STATION, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEORGE THOMAS MADDOX</b>				14. MOTHER'S M.A.DEN NAME <b>EVELYN DORSEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>MARGARET L. SHIPLEY</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Ischemic</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Interval between onset and death 3 mos</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1959</b> to <b>22 June 1961</b> , that (I) (we) last saw the deceased alive on <b>21 June 1961</b> , and that death occurred at <b>8:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. S. Murphy</b>				22b. DATE SIGNED <b>22 June 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. S. Murphy</b>				22d. ADDRESS <b>615 W. Montgomery, Rockville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-26-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>		23d. LOCATION (City, town or county) (State) <b>Sykesville, Carroll Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight</b>				25a. REC'D BY REGISTRAR <b>June 26 '61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur A. Haight</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7029

07016

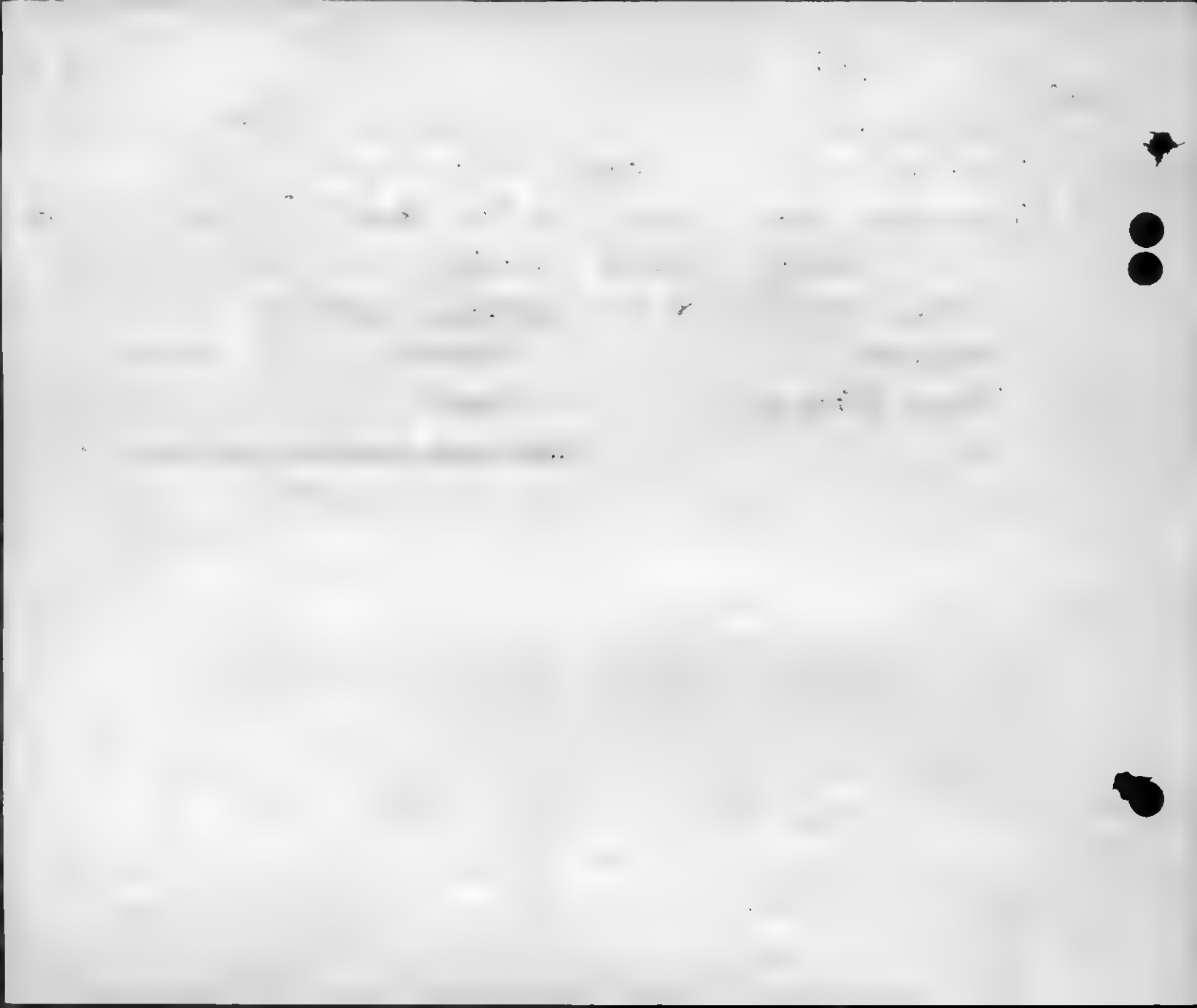
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> Montgomery		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>a. STATE</b> Maryland	
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) Takoma Park		<b>b. COUNTY</b> Montgomery	
<b>c. LENGTH OF STAY</b> N 15 19 days		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) Washington Sanitarium and Hospital		<b>d. STREET ADDRESS</b> 9810 Arborhill Drive	
<b>3. NAME OF DECEASED</b> Goldie		<b>4. DATE OF DEATH</b> June 13 1961	
<b>5. SEX</b> Female		<b>6. COLOR OR RACE</b> White	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> September 10, 1885 75 yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) Russia		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>13. FATHER'S NAME</b> Jacob Minkin		<b>14. MOTHER'S MAIDEN NAME</b> Sarah (Deceased)	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> NONE	
<b>17. INFORMANT</b> Washington Sanitarium and Hospital Records		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) Carcinoma of the pancreas	
<b>PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</b> 157X		<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> -	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) -		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) -	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) -		<b>20f. (City or town)</b> (County) (State) -	
<b>21. I certify that (I) (this hospital) attended the deceased from...</b> 5-26, 1961 <b>to</b> 6-13, 1961 <b>that (I) (we) last saw the deceased alive on</b> 6-12, 1961 <b>and that death occurred at</b> 4:30 AM <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> Abraham W. Davis		<b>22b. DATE SIGNED</b> 6-13-61	
<b>22c. PHYSICIAN'S NAME (Type)</b> ABRAHAM W. DAVIS		<b>22d. ADDRESS</b> 927 Pershing Rd. Silver Spring Md.	
<b>23a. BURIAL, CREMATION, OR REMOVAL (Specify)</b> Burial		<b>23b. DATE THEREOF</b> 6/14/61	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> GEO. WASH. CEM.		<b>23d. LOCATION (City, town or county)</b> Hyattsville Md.	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Charles J. Thomas		<b>25a. REC'D BY REGISTRAR</b> DATE JUN 14 '61	
<b>25b. REGISTRAR'S SIGNATURE</b> Charles J. Thomas			

TO HOSPITAL: The law requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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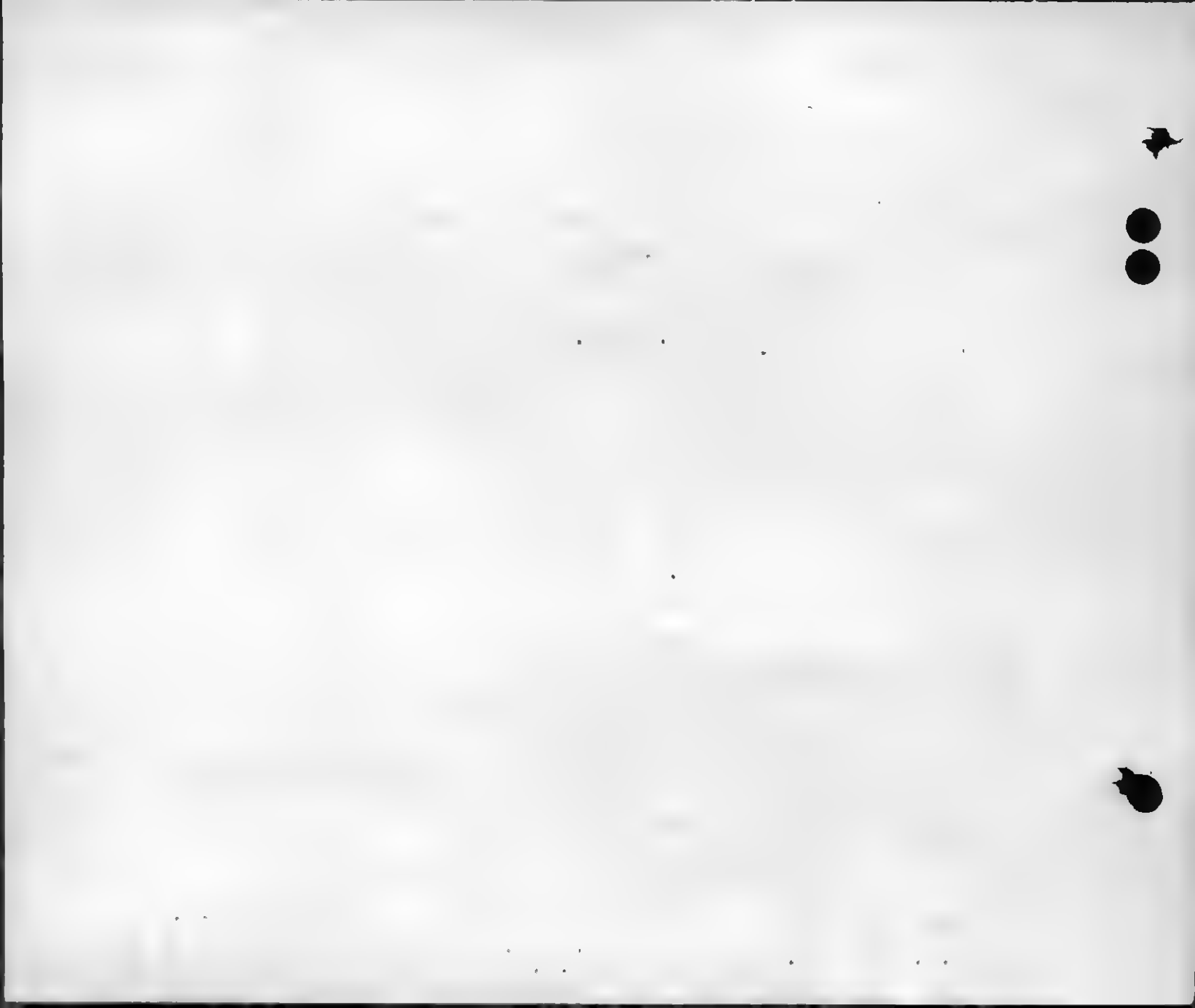
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7030

07017

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>517 Albany Avenue</u> <u>Oakhaven Convalescent Home</u>				d. STREET ADDRESS <u>1707 Columbia Road N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Tallulah de Sales Smith</u>				4. DATE OF DEATH Month Day Year <u>June 30 1961</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 21, 1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt Worker - Claim Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Adm.</u>			
11. BIRTHPLACE (State or foreign country) <u>Texas</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Dr. Zadoc Baker</u>				14. MOTHER'S MAIDEN NAME <u>Tallulah Abrams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>no</u>			
17. INFORMANT Address <u>Mrs John Moulden 1107 Merwood Dr. Takoma Park Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO 171X Condit on, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>METASTATIC CARCINOMA</u> DUE TO (c) <u>CARCINOMA OF THE CERVIX</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 1960</u> to <u>6-30-1961</u> that (I) (we) last saw the deceased alive on <u>6-29-1961</u> and that death occurred at <u>4M</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Merrill C. Quinlan Jr.</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>MERRILL C. QUINNAN JR. MD.</u>				22d. ADDRESS <u>7600 CARROLL AVE TAKOMA PARK, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/1/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co.</u>				25a. REC'D BY REGISTRAR <u>DATE JUL 3 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

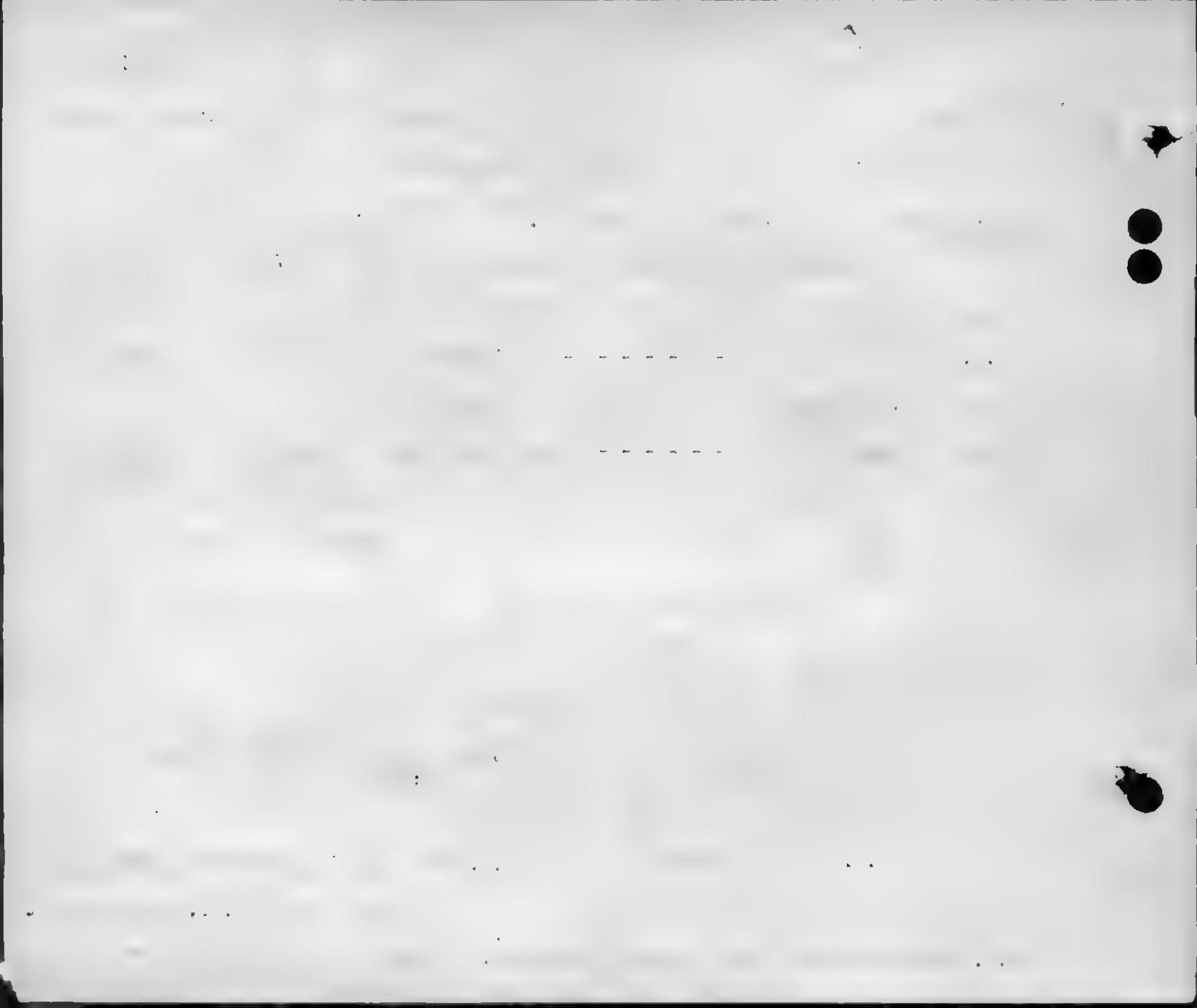
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15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

7031

07018

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY in lb <b>13 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. NAVAL HOSPITAL, INMC, BETHESDA, MD.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>8317 41th Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Dennis Keith SMITHERS</b>		4. DATE OF DEATH <b>June 23 19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>1-13-82</b>		8. DATE OF BIRTH <b>79 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>		11. BIRTHPLACE (County & State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Howard S. SMITHERS</b>		14. MOTHER'S MAIDEN NAME <b>Helen MANN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>(S) Robert Howard SMITHERS</b>	
17. INFORMANT <b>(S) Robert Howard SMITHERS</b>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>421.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10 June 1961</b> to <b>23 June 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>23 June 1961</b> and that death occurred <b>9:20PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William P. Baker</b>		22b. DATE SIGNED <b>6-24-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.P. BAKER LT MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-26-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek</b>		23d. LOCATION (City, town or county) (State) <b>Church Road, N.W., Washington, DC</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07019

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dist of Columbia</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>6201 12th St NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>ELLA R. SNAPP</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>February 26 1875</u> 9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>7</u> Year <u>1961</u> 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>JOHN SHIRLEY</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>REBECA</u> <b>17. INFORMANT</b> <u>Lola V. Kelley (Niece)</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>NAGLEY</u> Address <u>11011 Amherst Dr. Silver Spring, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 420.0 DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>July 1, 1961</u> Hour a.m. <u>19</u> p.m. <u>00</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> (County) (State) <u>Winchester VA</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 1, 1961</u> <b>to</b> <u>June 8, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>6/7</u> <b>1961, and that death occurred at</b> <u>11:30 PM</u> <b>from the causes and on the date stated above</b>			
<b>22a. SIGNATURE</b> <u>John E. Everett M.D.</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>JOHN E. EVERETT</u>		<b>22b. DATE SIGNED</b> <u>6/8/61</u> <b>22d. ADDRESS</b> <u>9400 CONN. AVE KENSINGTON MD</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>6-10-61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. HERBON</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>WINCHESTER VA</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>DEAN FUNERAL HOME</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JUN 12 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>25c. ADDRESS</b> <u>4812 MacArthur Blvd Washington</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

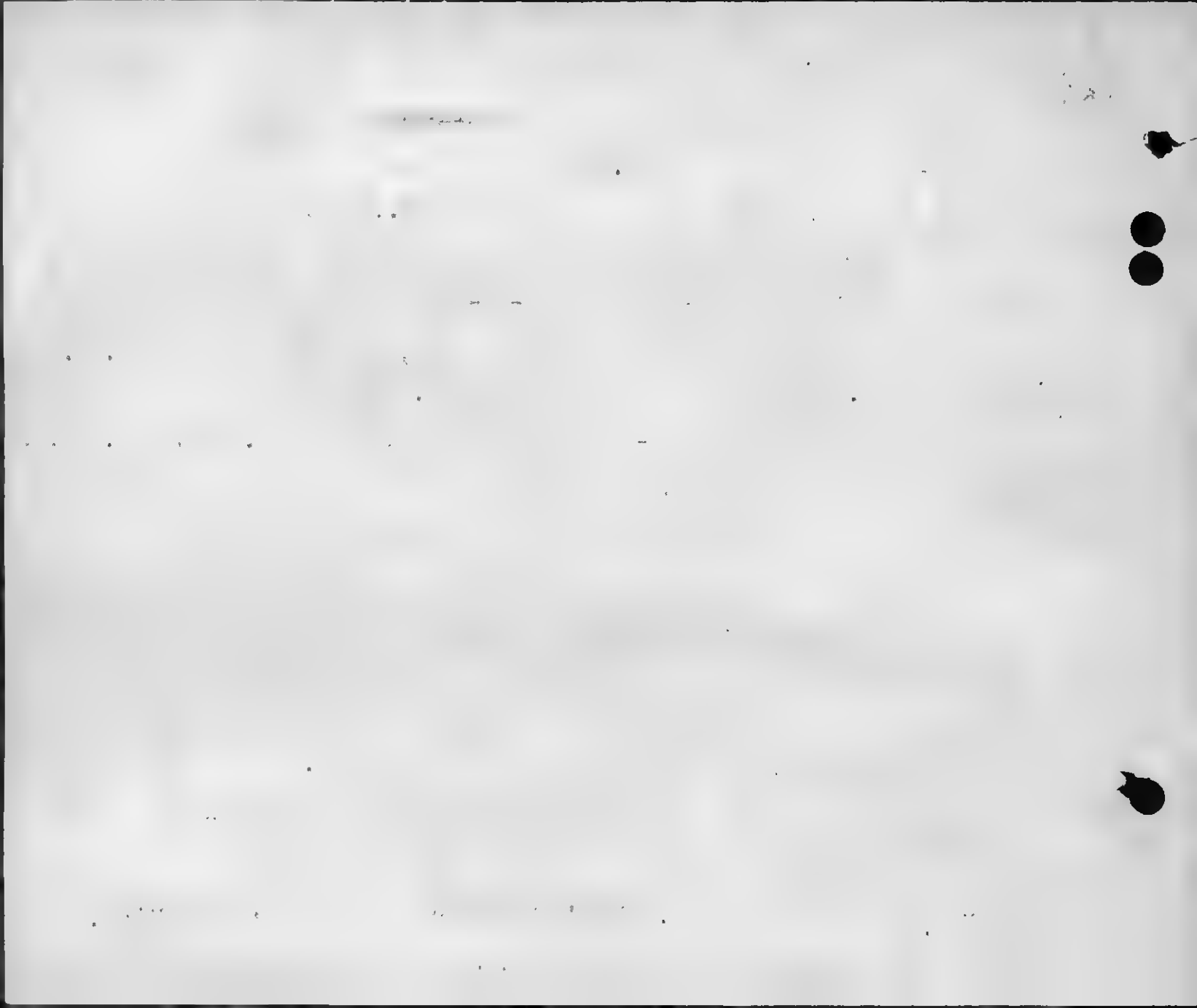
7033

07020

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> c. LENGTH OF STAY IN 1b <u>7 mos. 3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Waverley Sanitarium</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington 7</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>418-3</u> d. STREET ADDRESS <u>3252 O St., N. W.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Martha</u> <u>Norton</u> <u>Spencer</u> First Middle Last		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>20</u> Year <u>19 61</u>	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>D. VORCED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-12-1882</u> <b>9. AGE</b> (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>9</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>61</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Buffalo, New York</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U. S. A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Nathaniel W. Norton</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary C. Minor</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>-----</u> <b>17. INFORMANT</b> <u>Mrs Henry Day, 3252 O St., N.W. Wash. 7 D.C.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> (b) <u>Arteriolosclerosis Generalized</u> (c) <u>Senility</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Chronic Nephritis (Nephrosclerosis)</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19 61</u> Hour a.m. <u>11-17-60</u> p.m. <u>2:50 p.m.</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>1150 Conn Ave. N.W.</u>		<b>20f. (City or town)</b> <u>Litchfield, Connecticut</u> <b>(County)</b> <u>St. Michael's churchyard</u> <b>(State)</b> <u>6-20-61</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-17-60</u> <b>to</b> <u>6-20-61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>6-20-61</u> <b>and that death occurred at</b> <u>2:50 p.m.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Frederic J. Chapman</u> M.D.		<b>22b. ADDRESS</b> <u>1150 Conn Ave. N.W.</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Frederic J. Chapman</u>		<b>22d. ADDRESS</b> <u>1150 Conn Ave. N.W.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>6/23/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Michael's churchyard</u> <b>23d. LOCATION (City, town or county)</b> <u>Litchfield, Connecticut</u> <b>(State)</b> <u>6-20-61</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frederic J. Chapman</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JUN 22 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>	

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07021

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10,026 Lorain Avenue</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>13 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10,026 Lorain Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>August P. Spigone</u>		4. DATE OF DEATH <u>June 16, 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 11, 1882</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chef.</u>		11. BIRTHPLACE (State or foreign country) <u>Rome Italy</u>	
13. FATHER'S NAME <u>Guy Spigone</u>		14. MOTHER'S MAIDEN NAME <u>Maria Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-14-3495</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (e), stating the underlying cause last. _____		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus -----Years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 20, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or country) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 22 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7035

Reg. Dist. No. 07022

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution) Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>315 Broadwood Dr</u>				d. STREET ADDRESS <u>1315 Broadwood Dr</u>			
3. NAME OF DECEASED (Type or print) <u>Michael John Stahl</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-22-61</u>	
9. AGE (in years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u>		IF UNDER 24 MRS. Hours <u></u> Min. <u></u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Stahl</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Family Service Montg Co - Rockville Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>475x</u> IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>upper Respiratory Infection</u> DUE TO causing the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>Dead in bed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHECHT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>6-3-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lishburn</u>		22d. LOCATION (City, town, or county) (State) <u>Harrisburg, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave., Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 7 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, it is necessary to please execute the certificate within the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





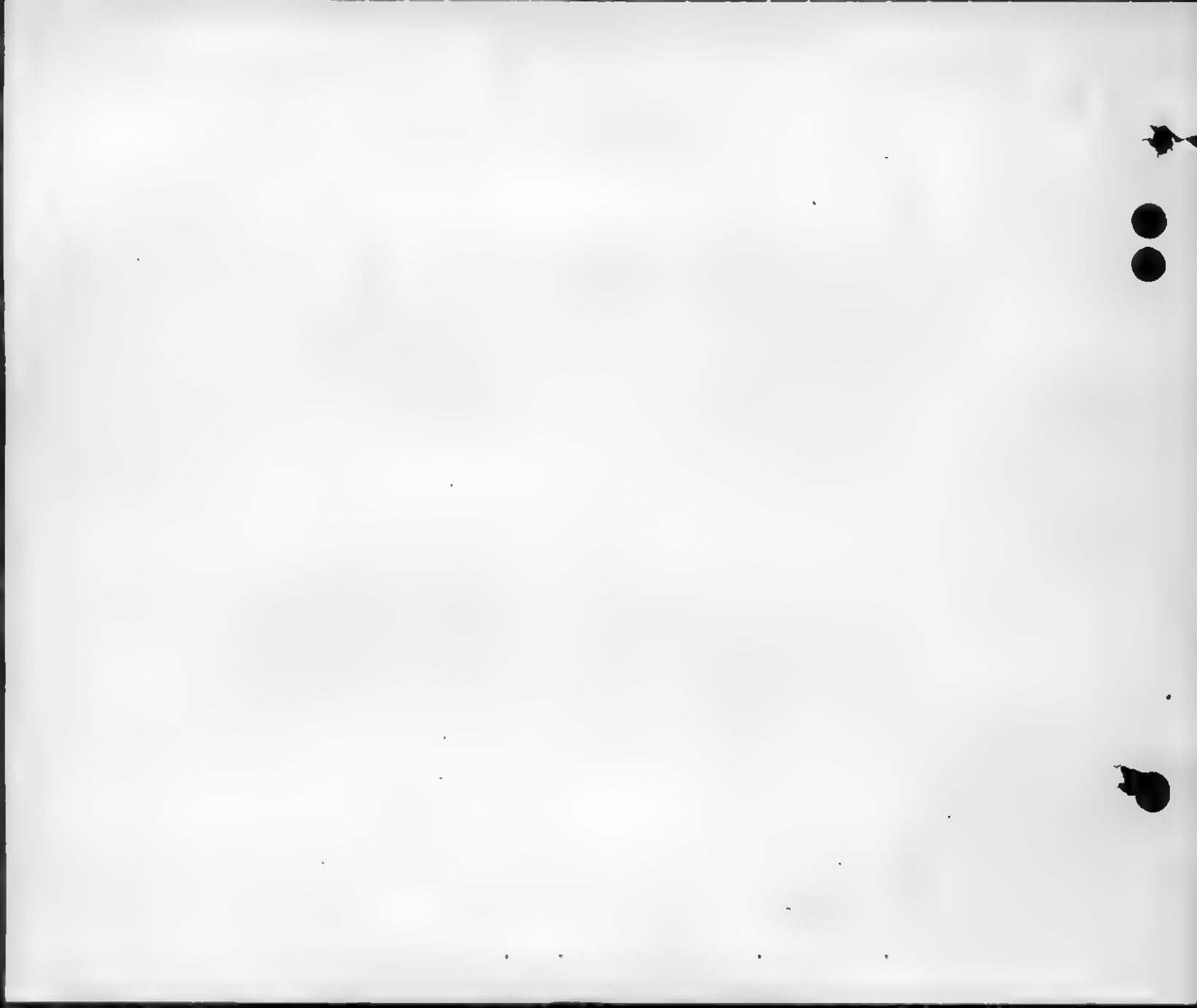
TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. If the deceased was in a hospital or attending physician, the certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

07023

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>R-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>WILLIAM</b> Last <b>STANG</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>19,</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 2nd 1874</b>		9. AGE (In years last birthday) <b>87</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>FREDERICK STANG</b>			14. MOTHER'S MAIDEN NAME <b>Rosealthe Mossburg</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular Accident.</b> DUE TO (c) <b>Hypertension</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>2/13, 1961</b>	
20f. (City or town) (County) (State) <b>GAITHERSBURG, MARYLAND</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>2/13, 1961</b> to <b>2/19, 1961</b> , that (I) (we) last saw the deceased alive on <b>2/19, 1961</b> , and that death occurred <b>10:45 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Ernest C. Gartner</b>		M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>E. I. LEAL, M. D.</b>		22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-21-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	
23d. LOCATION (City, town, or county) (State) <b>Gaithersburg Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 21 '61</b>	
25b. REG. STRAR'S SIGNATURE <b>Carlton S. Kneass</b>					

I







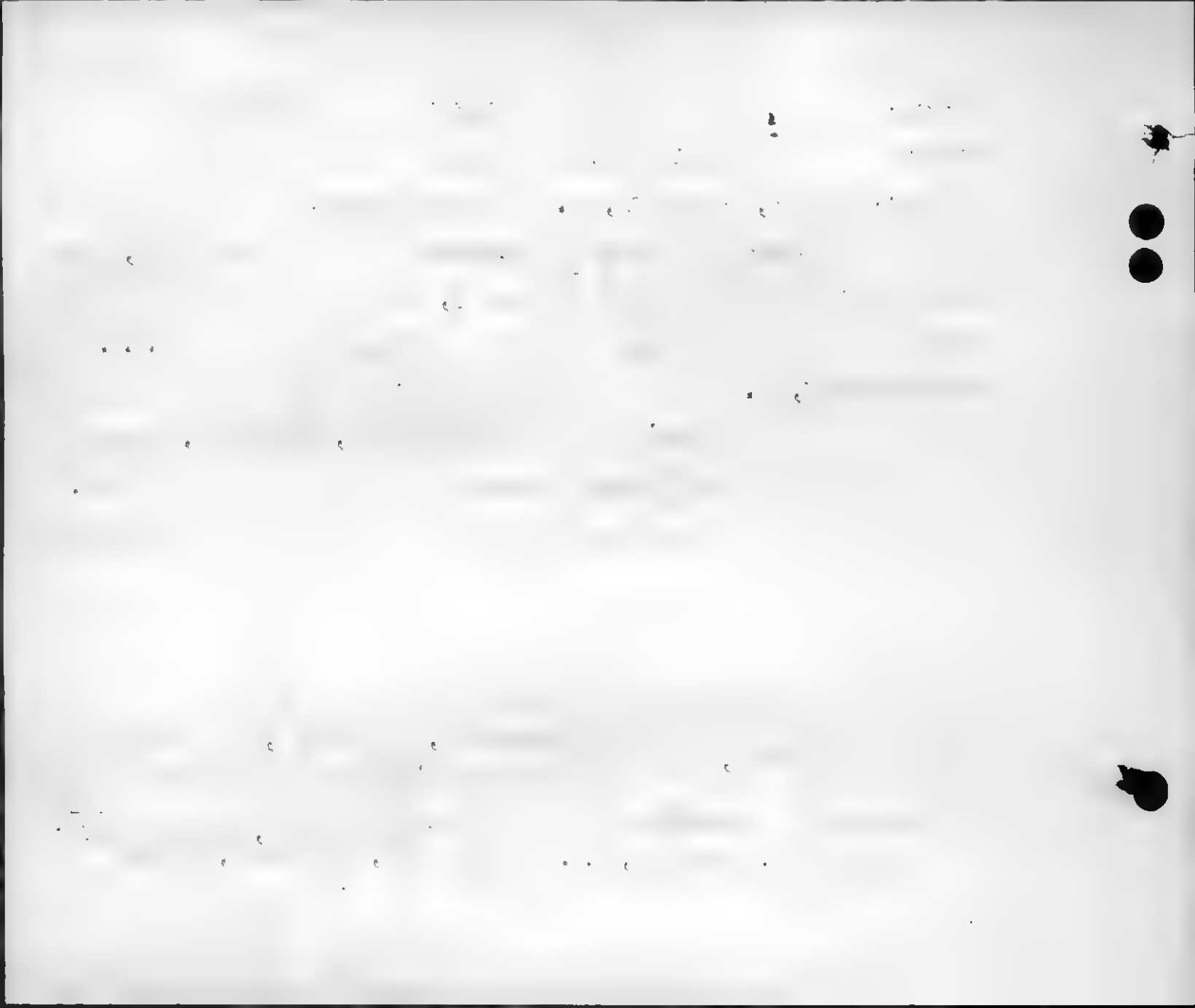
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7038

07025

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fazewell</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>171 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Amonate</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>No street address</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Benny</b> Last <b>Sutherland</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 3, 1944</b>	
9. AGE (In years last birthday) <b>17</b> yrs		10. IF UNDER 1 YEAR Months <b>17</b> Days <b>17</b> Hours <b>17</b> Min <b>17</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Denny Sutherland, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Faye Harrison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Lymphatic Leukemia</b> <b>204.3</b> DUE TO <b>Gram Negative Septicemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gram Negative Septicemia</b> DUE TO (c) <b>Gram Negative Septicemia</b> INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b> <b>1 week</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>December 15, 1960</b> to <b>June 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 4, 1961</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard E. Rieselbach</b>				22b. DATE <b>6-5-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>RICHARD E. RIESELBACH, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/6/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Richlands, Va.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chamber Co</b>				25a. REC'D BY REGISTRAR <b>1400 Chapman St</b>		25b. REGISTRAR'S SIGNATURE <b>W. W. Chamber</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

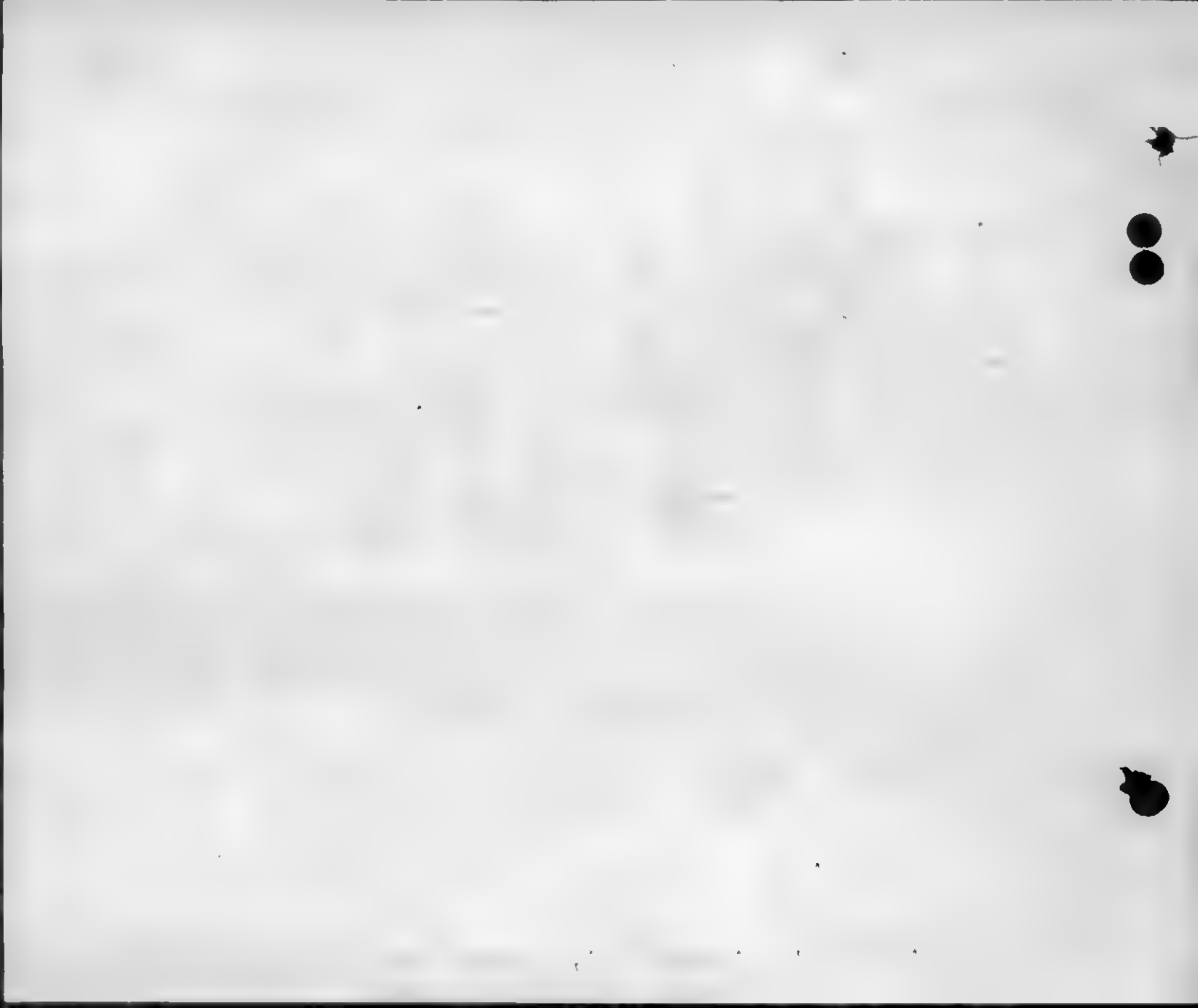
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

X

(I)

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Montgomery</u> <b>b. CITY OR TOWN</b> <u>Silver Spring</u> <b>c. LENGTH OF STAY IN 1b</b> <u>1 1/2 yrs</u> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> <u>10614 Edgewood Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>a. STATE</b> <u>Maryland</u> <b>b. COUNTY</b> <u>Montgomery</u> <b>c. CITY OR TOWN</b> <u>Silver Spring</u> <b>d. STREET ADDRESS</b> <u>10614 Edgewood Ave</u> <b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Rosalie B Taylor</u> <b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>Cauc</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>30 Aug 1897</u> <b>9. AGE</b> (In years last birthday) <u>63</u> <b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> <b>IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>				<b>4. DATE OF DEATH</b> <u>June 9 1961</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Post Clerk</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Govt</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Wash. DC</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>John S. Taylor</u> <b>14. MOTHER'S MARRIED NAME</b> <u>M. Mary Nealon</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Sister (Grace R. Noone)</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>myocardial infarction</u> <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <u>arteriosclerotic cardio-vascular disease</u> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b> <u>None</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER!) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>June 1961</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <u>Silver Spring</u> <b>(County)</b> <u>Montgomery</u> <b>(State)</b> <u>Md.</u>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 1961</u> <b>to</b> <u>June 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>8 June 1961</u> <b>and that death occurred at</b> <u>8:30 AM</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Paul T. Noone</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Paul T. Noone</u>				<b>22b. DATE SIGNED</b> <u>June 13 1961</u> <b>22d. ADDRESS</b> <u>6201 Randolph Rd. Silver Spring, Md.</u>				<b>22e. REC'D BY REGISTRAR</b> <u>Arthur S. Hume</u> <b>22f. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>			
<b>23a. BURIAL (CREMATION, REMOVAL) (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>6/12/61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fairview Cemetery</u> <b>23d. LOCATION</b> (City, town or county) <u>Montgomery County</u> <b>(State)</b> <u>Md.</u>				<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc.</u> <b>25. ADDRESS</b> <u>8434 Georgia Avenue Silver Spring, Maryland</u> <b>25a. REC'D BY REGISTRAR</b> <u>DATE JUN 13 '61</u>							





DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

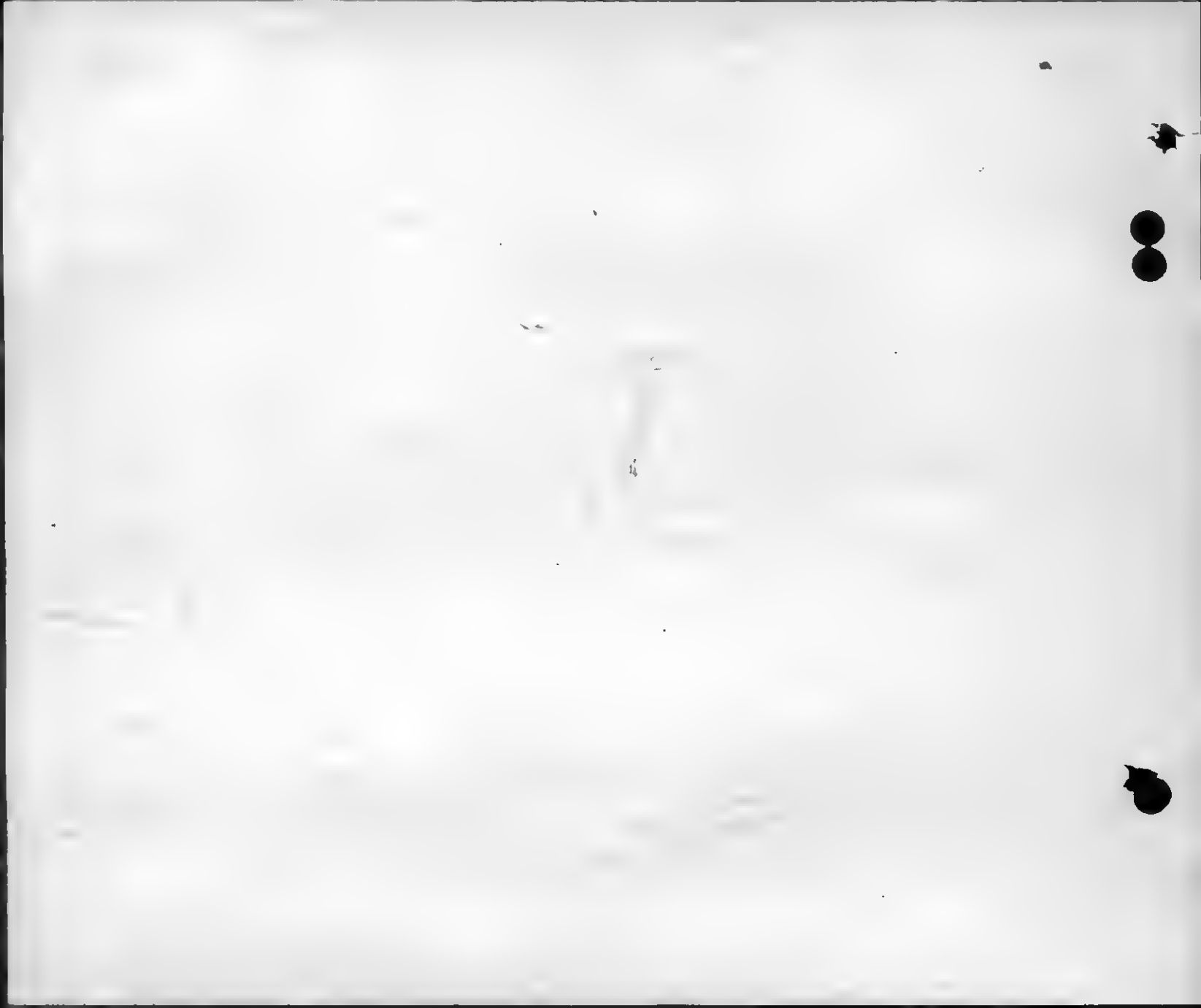
7040

Item 2 Film 6200

07/01/61

07025

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASH.</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>4419 36th St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>L.</b> Last <b>Tollaksen</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1878</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Amos Bliss</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Shepherd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b> 420.1 DUE TO <b>Sensitivity (age 83)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Coronary Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coroner notified and will appear 19 June 61</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6/5/61</b> 19 to <b>6/5/61</b> 19, that (I) (we) last saw the deceased alive on <b>6/5/61</b> 19, and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>SAM ALLEN</b> <b>SAM ALLEN, M.D.</b> <b>Kensington, Maryland</b>		22b. ADDRESS	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL (CREMATION) REMOVAL (Specify)	23b. DATE THEREOF <b>6/5/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Bladenboro Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Funeral Home, m.w. &amp; c.</b>		25a. REC'D BY REGISTRAR <b>JUN 8 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Turner</b>



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

7041

07028

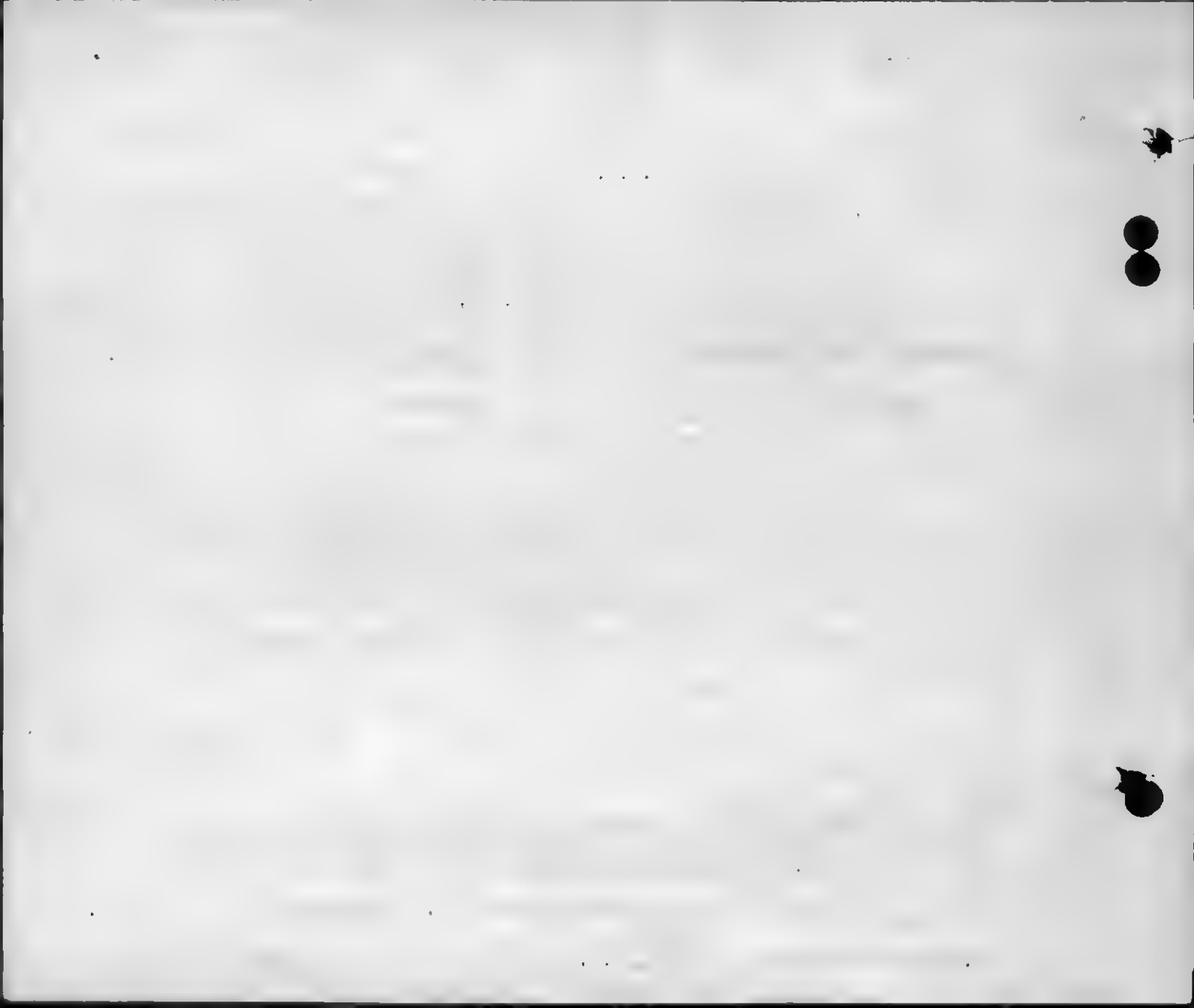
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN town <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SILVER SPRING DRIVEWAY, 905 BONFANT STREET</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>10301 - 16th STREET, APT. 303</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>SONDRA TRAGER</b>				4. DATE OF DEATH <b>JUNE 26 19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 25, 1936</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REGISTERED NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>MARCUS COHEN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO <b>UNKNOWN</b> 17. INFORMANT <b>POLICE RECORDS</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE AND LACERATION</b> 176X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>BULLET WOUND THROUGH SKULL</b> (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a: <b>FOUND DEAD IN HER AUTO WITH SELF INFLICTED BULLET WOUND THROUGH SKULL</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>2</b> p.m. <b>JUNE 26 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>AUTO IN DRIVEWAY</b>		20f. (City or town) <b>SILVER SPRING, MONTGOMERY, MD.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/28/61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>OHR KNEESETH ISRAEL CEM.</b>				22d. LOCATION (City, town, or country) <b>Baltimore Md.</b>			
23. FUNERAL DIRECTOR <b>B. Danzansky &amp; Sons</b>				24a. REC'D BY REGISTRAR <b>JUN 28 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

**SUDDEN**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒



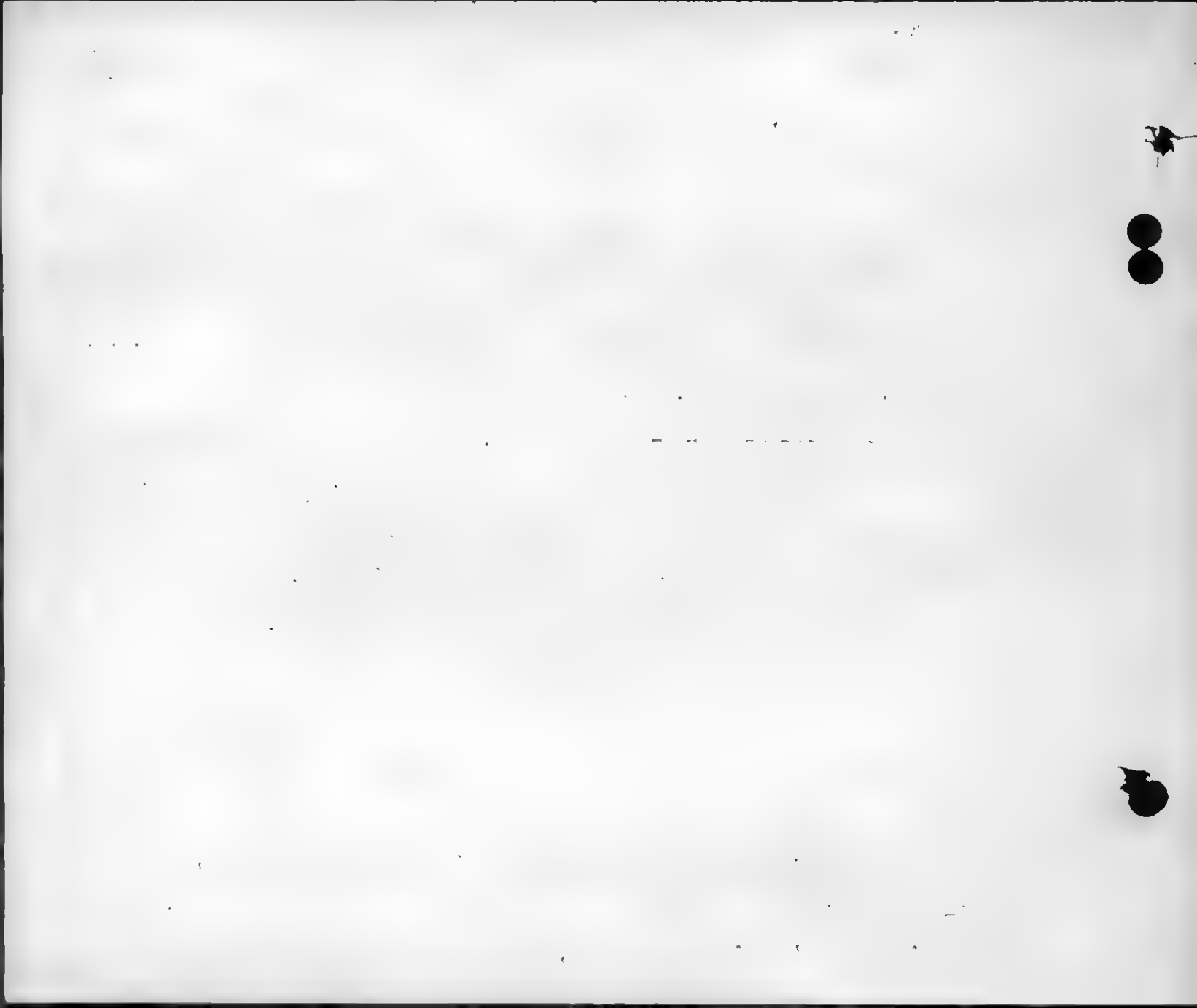
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07029

7042

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN Ib <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Milo M</b> Middle <b>Van Noy</b> Last <b>Van Noy</b>				4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/23/93</b>	
9. AGE (In years last birthday) <b>67</b>		10. AGE (In years last birthday) <b>67</b>		11. AGE (In years last birthday) <b>67</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Worker</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>Anderson L. Van Noy</b>				14. MOTHER'S MAIDEN NAME <b>Etura Dunson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>501-09-8972</b>		17. INFORMANT <b>Mary L. Nigh (daughter)</b> Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary Thrombosis</b> DUE TO (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus. Status postoperative, Amputation Right Leg.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>6-1</b> to <b>6-15</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>6-14</b> 19 <b>61</b> and that death occurred at <b>7 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Jason Geiger</b> M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) <b>Jason Geiger</b> 22d. ADDRESS <b>1112 Silver Spring Avenue, Silver Spring Maryland</b>							
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial-Transit</b> 23b. DATE THEREOF <b>6/16/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Paint Township Cemetery</b> 23d. LOCATION (City, town, or county) (State) <b>London Madison County Ohio</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner P. Pumphrey, Inc.</b> ADDRESS <b>8434 Georgia Avenue Silver Spring, Maryland</b> 25a. REC'D BY REGISTRAR <b>DATE JUN 19 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Cl. Shaw &amp; Knaus</b>							

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

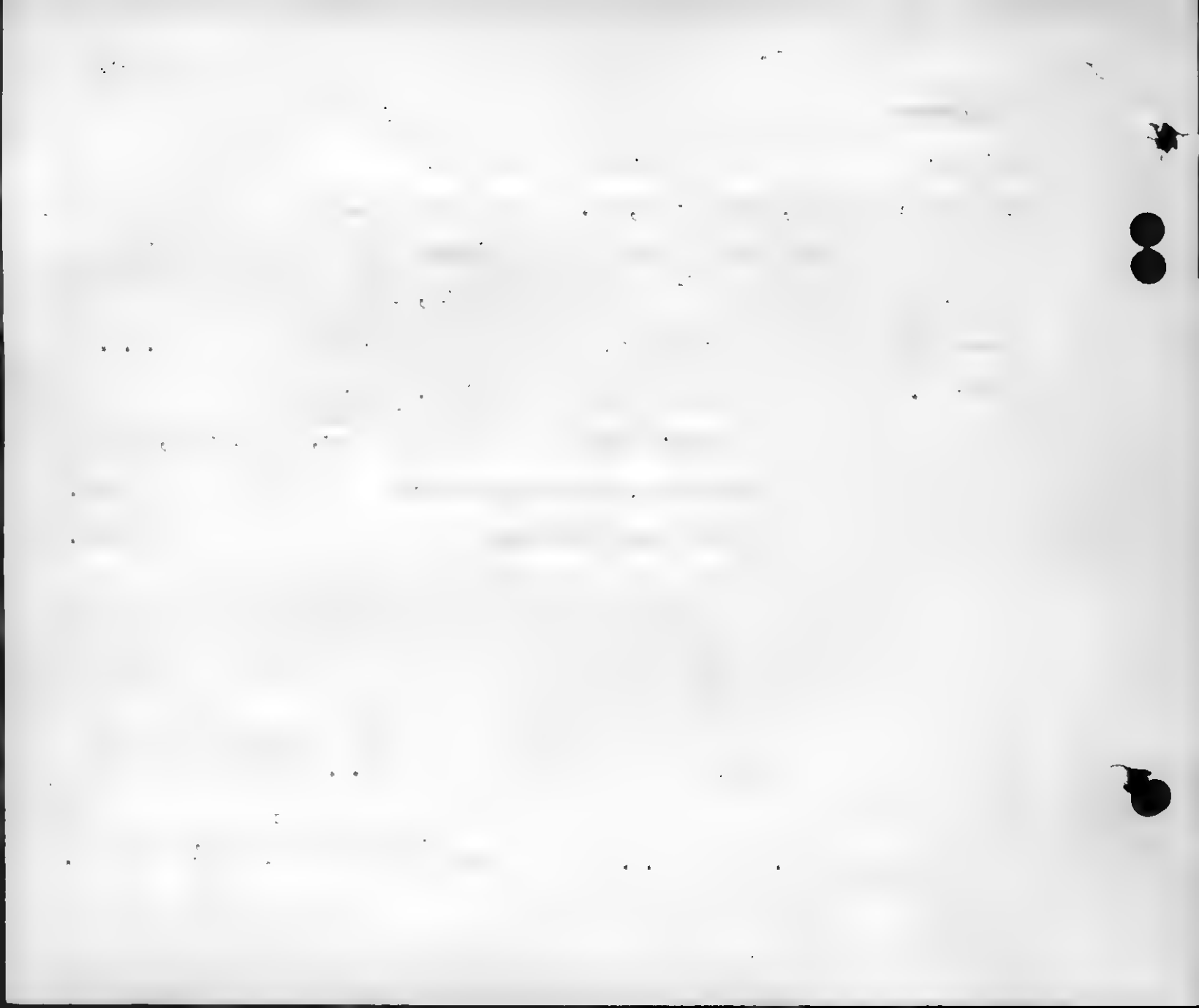
7043

07030

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>74 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Bluefield</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>85X-2</b> d. STREET ADDRESS <b>226 Larch Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Charlotte</b>		First <b>Charlotte</b>		Middle <b>Louise</b>		Last <b>Vincent</b>		4. DATE OF DEATH Month <b>June</b>		Day <b>19</b>		Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 28, 1915</b>		9. AGE (In years last birthday) <b>45</b>		IF UNDER 1 YEAR Months <b>45</b>		IF UNDER 24 HRS Days <b>45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert H. Gilpin</b>						14. MOTHER'S MAIDEN NAME <b>Julia E. Hager</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Increased intracranial pressure</b> DUE TO 1939 Candidans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Glioblastoma Multiforme</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>4 mos.</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>April 6, 1961</b> to <b>June 19, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 19, 1961</b> , and that death occurred at <b>9:04 p.m.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Philip J. Ferris, M.D.</b>						22b. DATE SIGNED <b>6/20/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>PHILIP J. FERRIS, M.D.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>							
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6/22/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Roselawn Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Princeton, W. Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey,</b>						ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Robert S. Thomas</b>			

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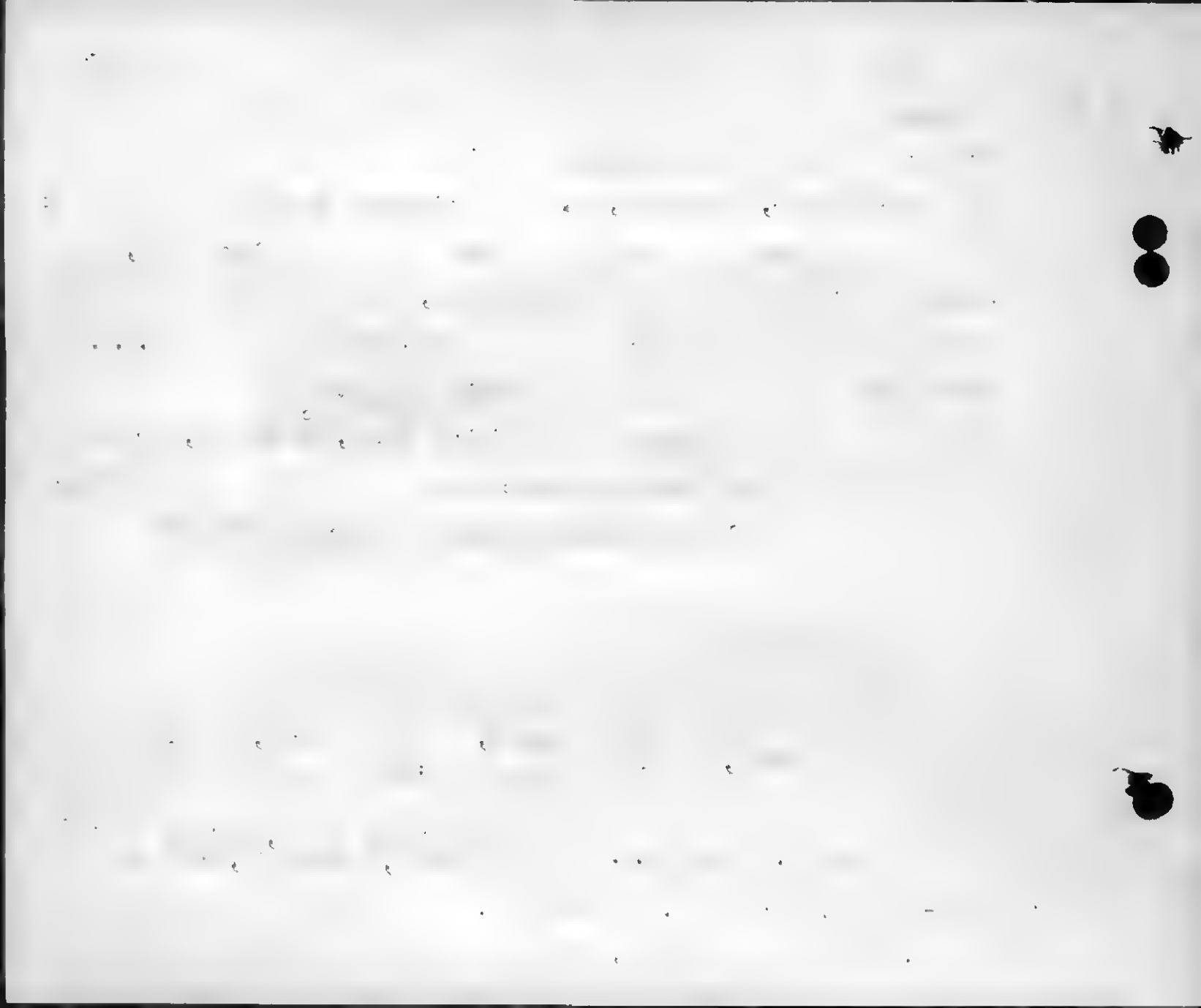
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7044

07031

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lodi</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>56 Christopher Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Mary</b> Middle <b>Ann</b> Last <b>Voto</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8,</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1955</b>		9. AGE (In years last birthday) <b>6</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Mm	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Voto</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Bauagnoli</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>754.0</b> IMMEDIATE CAUSE (a) <b>Post operative cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Following complete correction of tetralogy of Fallot</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>14 hours</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>June 4, 61</b> <b>June 8, 61</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>June 8, 61</b> to <b>June 8, 61</b> , that (I) (we) last saw the deceased alive on <b>June 8, 61</b> , and that death occurred at <b>5:30AM</b> from the causes and on the date stated above							
22a. SIGNATURE <i>James L. Talbert</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/8/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES L. TALBERT, M.D.</b>				22d. WHERE SIGNED <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-trans</b>		23b. DATE THEREOF <b>6/8/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Nicholas Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Lodi New Jersey</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 9 '61</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles S. Fournier</i>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.



1. The law requires that the death certificate be executed within 24 hours after death.

2. If the deceased was in a hospital or attending physician, the certificate should be signed by the attending physician and completely filled in by the funeral director.

3. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

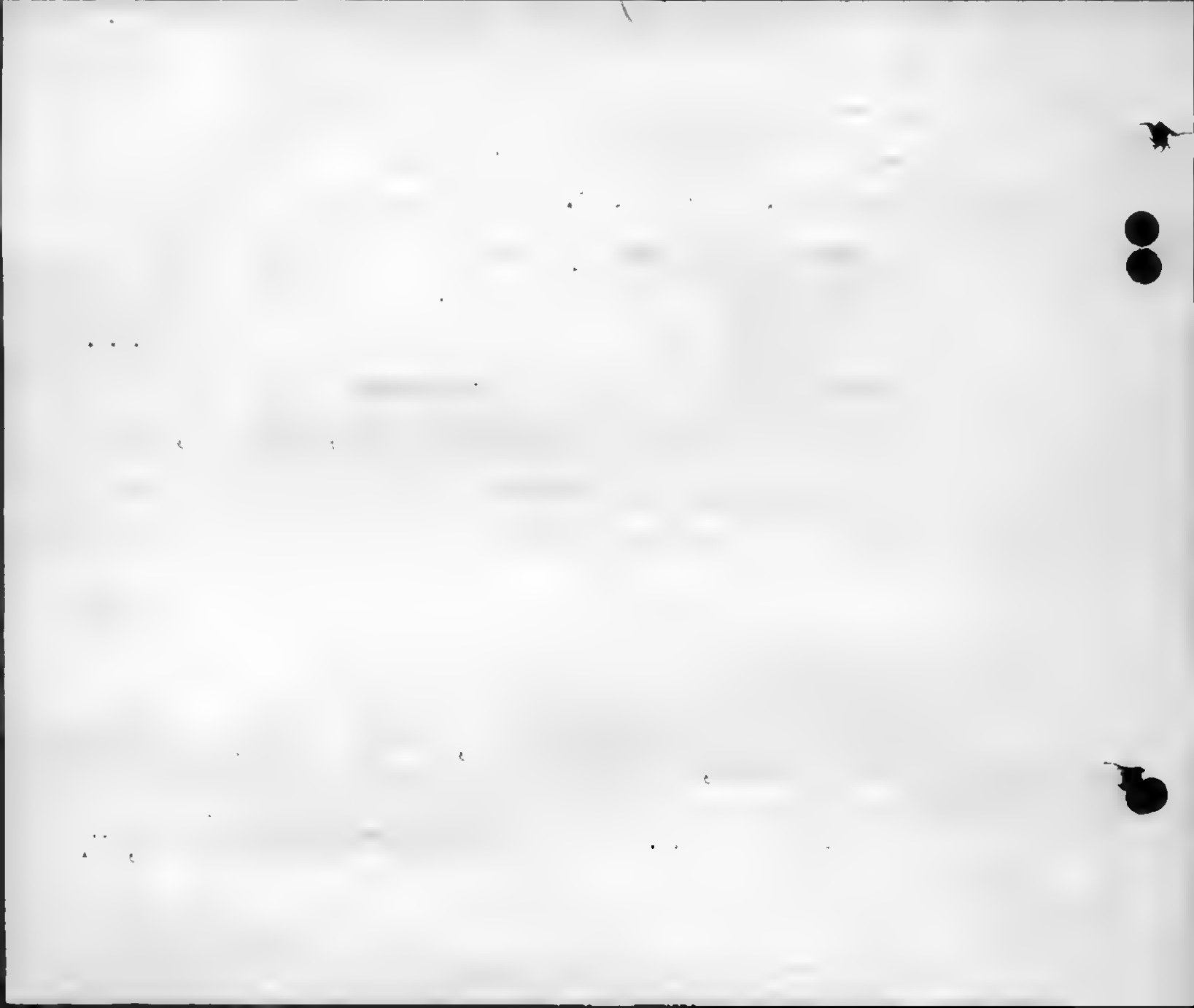
7045

07032

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>12 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cape May</b>			
f. STREET ADDRESS <b>1127 Indiana Avenue</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sherry</b>		First <b>Anne</b>		Middle <b>Walden</b>		Last	
4. DATE OF DEATH <b>June 23</b>		Month		Day		Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 21, 1954</b>		9. AGE (In years lost birthday) yrs. <b>6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stanley Walden</b>				14. MOTHER'S MAIDEN NAME <b>Joan Watton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; if unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 154.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Tetralogy of Fallot</b> DUE TO (c) <b>Congenital</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 11, 1961</b> , to <b>June 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 23, 1961</b> , and that death occurred at <b>10:00 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>O. W. Mc Bride</b>				M. D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> <b>6-21-61</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>O. W. Mc Bride M.D.</b>				22d. ADDRESS <b>National Institutes Of Health The Clinical Center, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>6-27-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cape May Court House N.J.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Riverdale Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7046

## CERTIFICATE OF DEATH

07033

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>24 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admittance) a. STATE <u>D.C.</u> b. COUNTY <u>V</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3133 Conn. Ave. n.w.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Elinor Gardiner Walker</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>14</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb. 1, 1881</u>	<b>9. AGE</b> (In years last birthday) <u>80</u> yrs IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Mins. <u>0</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Govt Employee</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>William J. Walker</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Adelaide Davis</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no</u>	
<b>17. INFORMANT</b> <u>Old Hospital Record</u>		<b>18. INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 weeks</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic - Inter-arterial</u> 442 DUE TO (b) <u>Hypertension - Ruptured - secondary and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>with kidney damage</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.</b> <u>injury no record</u>			
<b>20a. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		<b>20b. INJURY OCCURRED</b> 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Aug 24, 1959</u> <b>to</b> <u>June 14, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>June 13, 1961</u> , <b>and that death occurred at</b> <u>9:21</u> <b>M.</b> <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <u>Frank L. Williamson</u> M.D. <input type="checkbox"/> <b>22b. ADDRESS</b> <u>2701 14th St NW</u>	
<b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b> REMOVAL (Specify) <u>Cremation 6/16/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Crematory</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>St. Thomas Co.</u>		<b>25. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

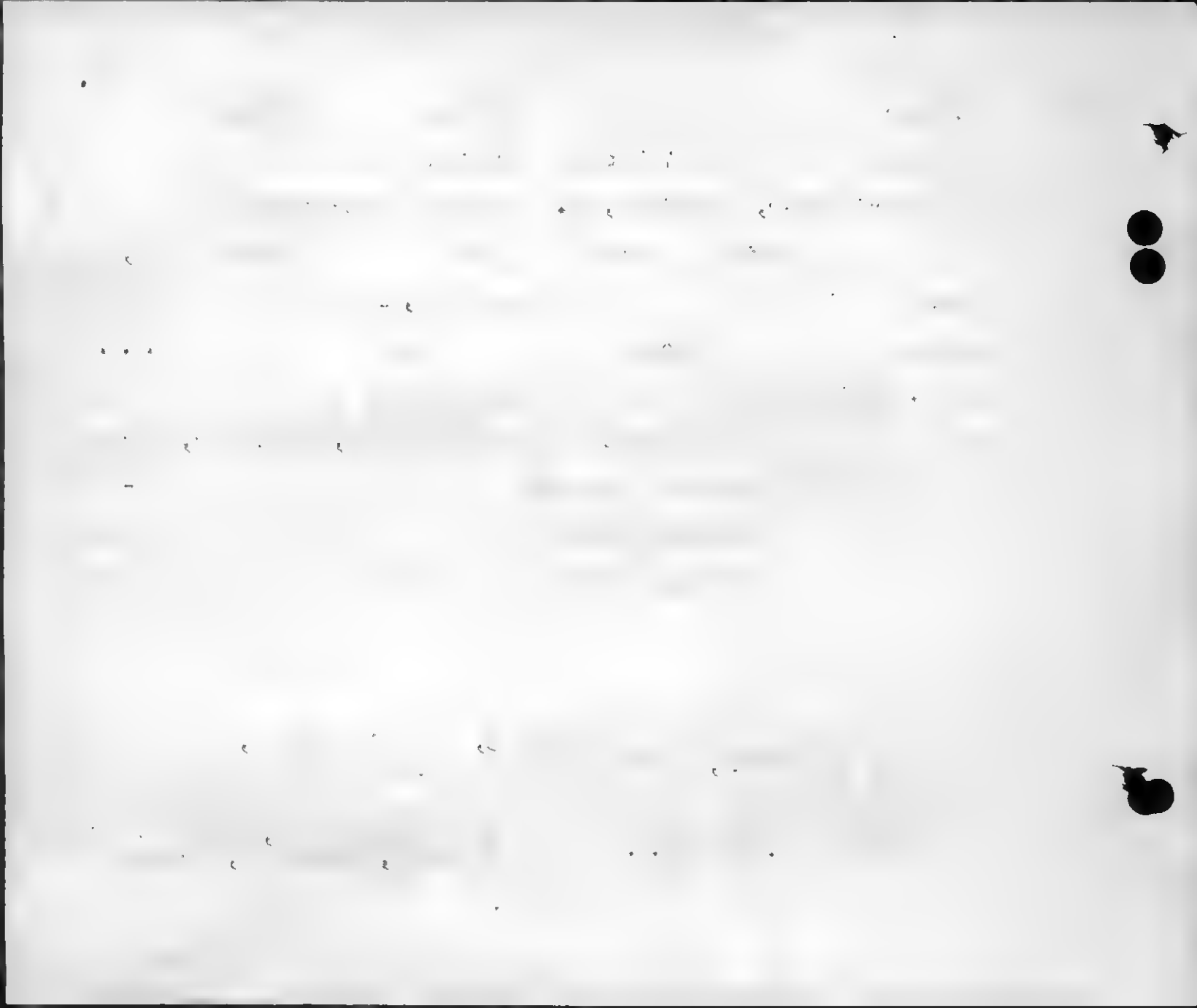
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7047

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07034

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Summerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>224 North Summerset Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>Mae</b> Last <b>Ward</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 27, 1894</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Riggan</b>		14. MOTHER'S MAIDEN NAME <b>Louise Lawson</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unavailable</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>			
DUE TO <b>Myasthenia Gravis</b>			
DUE TO <b>Arteriosclerotic Heart Disease</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 - 2 Hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 Year</b>			
Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 3, 19 61</b> to <b>June 10, 19 61</b> , that (I) (we) last saw the deceased alive on <b>June 10, 19 61</b> , and that death occurred at <b>5:00AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles A. Payne, M.D.</b>		22b. DATE SIGNED <b>6/10/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles A. Payne M.D.</b>		22d. <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-13-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Md.</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee, J. H. Horne</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 13 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Clark, J. H.</b>			

MEDICAL CERTIFICATION





**TO HOSPITAL OR** [REDACTED] **ENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. [REDACTED] Page 4 may be retained [REDACTED] hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORONER HAS BEEN NOTIFIED  
AND APPROVES.

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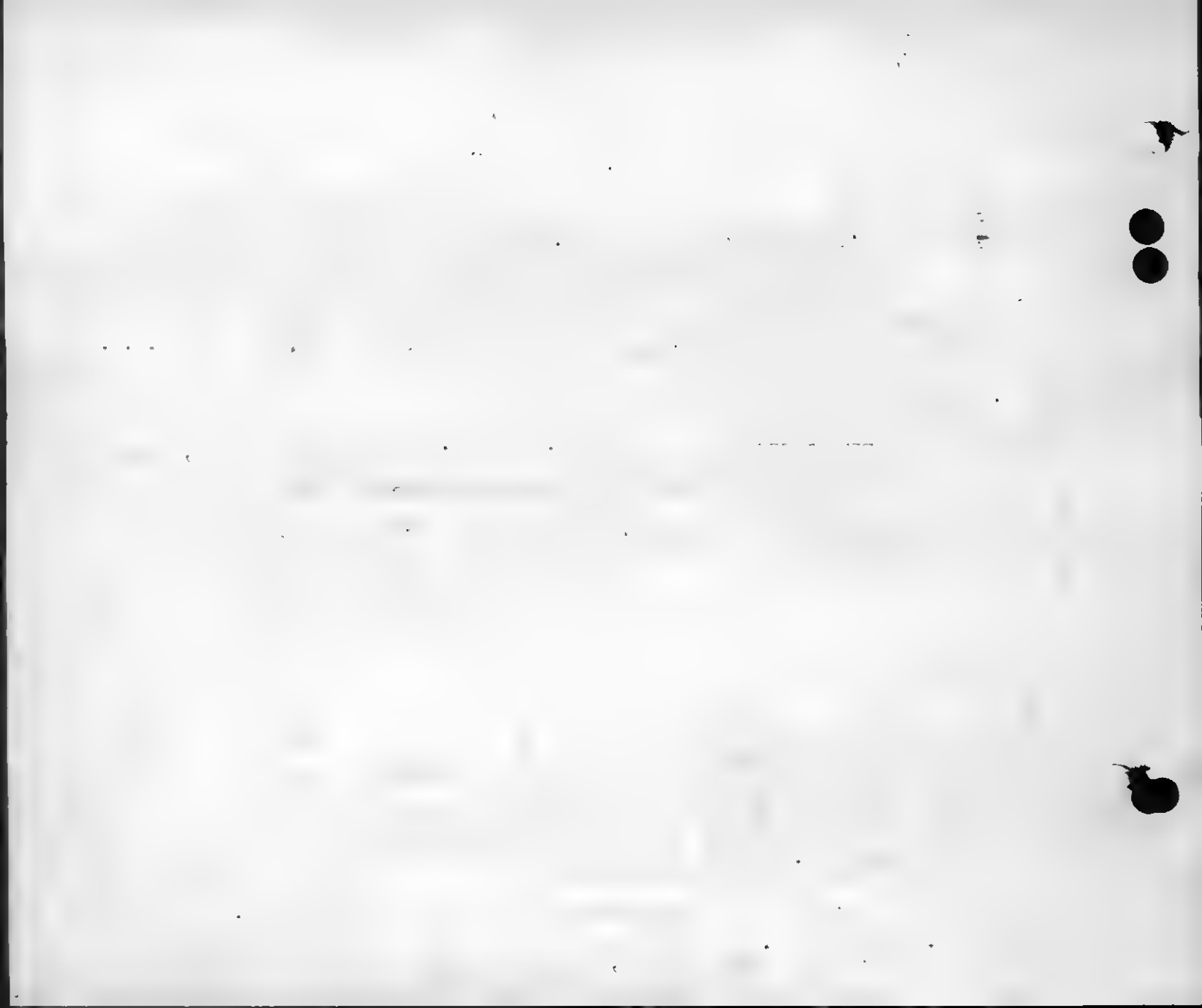
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7048

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

07035

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>eleven years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		<b>21</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>415 Penwood Road</b>				d. STREET ADDRESS <b>415 Penwood Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNE MARIE WARNER</b>				4. DATE OF DEATH Month <b>6</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/20/07</b>	
9. AGE (In years last birthday) <b>53</b> yrs		10. UNDER 1 YEAR Months <b>3</b> Days <b>15</b> Hours <b>15</b> Min. <b>15</b>		11. BIRTHPLACE (State or foreign country) <b>New York, New York.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York, New York.</b>	
13. FATHER'S NAME <b>Mr. Thomas Kennedy</b>				14. MOTHER'S MAIDEN NAME <b>Bridget Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>000-00-0000</b>				17. INFORMANT <b>Mr. Zolie V. Warner</b>		18. ADDRESS <b>415 Penwood Road Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Congestive HEART FAILURE</b> <b>416X</b> DUE TO <b>Chronic Rheumatic HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Rheumatic HEART DISEASE</b> DUE TO (c) <b>Chronic Rheumatic HEART DISEASE</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH MINUTES</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>June 1961</b> , that (I) (we) last saw the deceased alive on <b>APRIL 1961</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Bernard A. Fitzgerald</b>				22b. PHYSICIAN'S NAME (Type) <b>Bernard A. Fitzgerald</b>		22c. ADDRESS <b>217 UNIVERSITY BLVD E. S.S. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/19/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Montgomery Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				25a. REC'D BY REGISTRAR <b>JUN 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



Page 4  
24 hours after death  
by the funeral director,  
Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 07036

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash Sax &amp; Hospital</b>		d. STREET ADDRESS <b>5801 Taylor Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>H.</b> Last <b>Watts</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 28th 1910</b>
9. AGE (In years last birthday) yrs <b>50</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kentucky</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edward Watts</b>		14. MOTHER'S MAIDEN NAME <b>Martha Duval</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes.</b>		16. SOCIAL SECURITY NO. <b>10-10-10-2</b>	
17. INFORMANT <b>Blanche Watts 5801 Taylor Rd, Riverdale, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>1 year</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>6</b> p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-26-61</b> , 19 <b>61</b> , to <b>6-2-61</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5-31-61</b> , 19 <b>61</b> , and that death occurred on <b>6-2-61</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John P. Clum</b>		DATE SIGNED <b>6-2-61</b>	
PHYSICIAN'S NAME (Type) <b>John P. Clum</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 6-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Indel</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Costello</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 5 '61</b>	
ADDRESS <b>1722 N. Capital</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

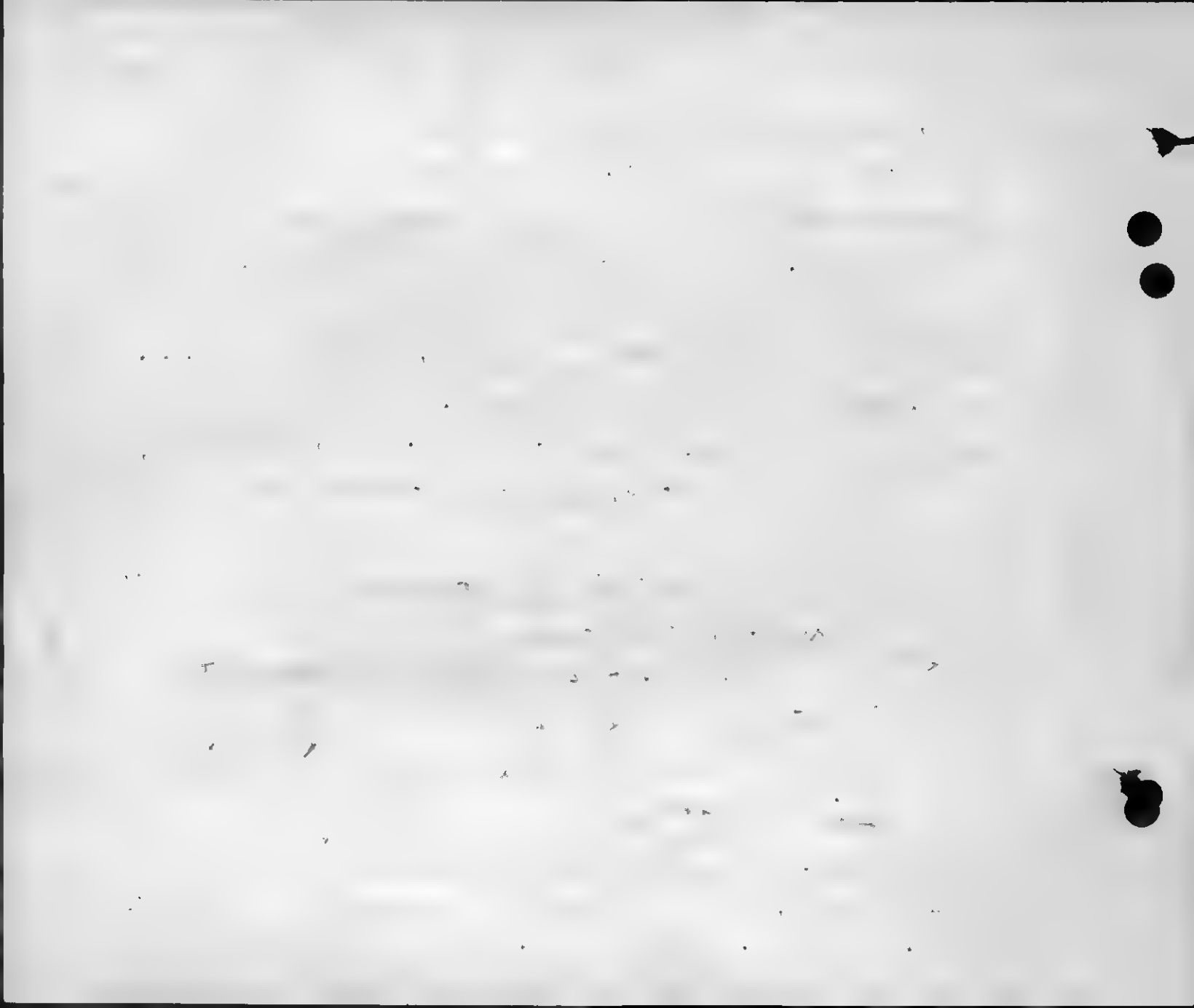
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

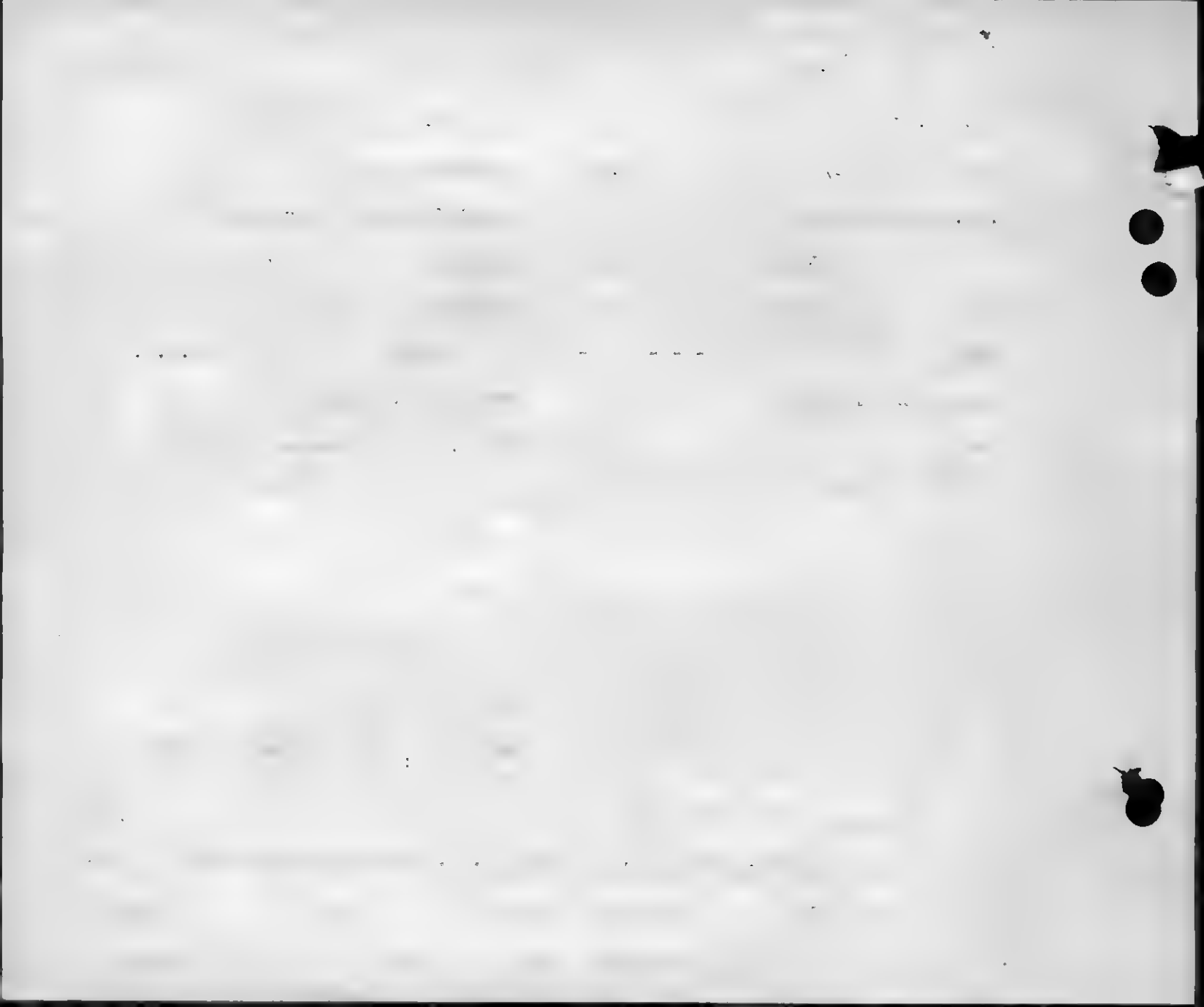
CERTIFICATE OF DEATH

7051

07038

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Patuxent River</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>773B MEMO Naval Air Station</b> d. STREET ADDRESS <b>773B MEMO Naval Air Station</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Helen Louise WHITE</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>June 7 1961</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5-30-28</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maine</b>	
<b>13. FATHER'S NAME</b> <b>Vernon L. FLEMMINGS</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Marietta M. BENNETT</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>(H) John W. White, same as #2 above</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>411</b> DUE TO <b>aortic insufficiency</b> Conditions, if any, which gave rise to immediate cause (b) <b>Rheumatic heart disease</b> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20f. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20g. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20h. (City or town)</b> (County) (State)	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 1 11:05PM</b> to <b>June 7 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 7 1961</b> , and that death occurred at <b>11:05PM</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Bruce Harold Rice</b> M.D.		<b>22b. DATE SIGNED</b> <b>6-8-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Bruce Harold RICE, LT, MC, USN</b>		<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial-Shipment</b>		<b>23b. DATE THEREOF</b> <b>6-9-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Grove Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Bath Maine</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>R. A. Humphrey</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JUN 9 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Carlton S. Hume</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7052

07039

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaKoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaKoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>25 Holt Place</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ethel Lee Williams</u>				4. DATE OF DEATH Month Day Year <u>6 30 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-7-07</u>	
9. AGE (In years last birthday) <u>54</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>J. Henry Chavey</u>				14. MOTHER'S MAIDEN NAME <u>Cordie Crawford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patient's Chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonic Heart Disease</u> DUE TO (b) <u>Congestive Cardiac Failure</u> DUE TO (c) <u>Chronic Glomerulo - Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>7 years.</u> <u>3 months</u> <u>3 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 1961</u> to <u>June 30 1961</u> , that (I) (we) last saw the deceased alive on <u>June 30 1961</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert A. Hare</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. HARE</u>				22d. ADDRESS <u>7600 Carroll Ave. T.P. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>July 4, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville TENN.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>254 Carroll St NW. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 3 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

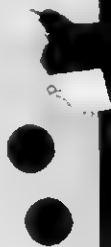


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07040

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>18 YEARS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>728 EASLEY STREET</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>728 EASLEY STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JUDITH E. WILLIS</b>		4. DATE OF DEATH Month Day Year <b>JUNE 18 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 10, 1881</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>PORTSMOUTH, No. CAR.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ALONZO ENGLISH</b>	
14. MOTHER'S MAIDEN NAME <b>CORA NEWTON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO.</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>INEZ A. BAILEY, 728 EASLEY ST., SILVER SPRING, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO <b>5 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>CEREBRO VASCULAR ACCIDENT (Feb. 27, 1961).</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>March 15, 1961, to June 18, 1961</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 15, 1961</b> , to <b>June 18, 1961</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>June 10, 1961</b> , and that death occurred at <b>4AM</b> , from the causes and on the date stated above			
22a. 5 CHAISE <b>Belden R. Reap M.D.</b>		22b. DATE SIGNED <b>June 18, 1961</b>	
22c. PHYSICIAN'S Name (Type) <b>BELDEN R. REAP, M.D.</b>		22d. ADDRESS <b>11602 GRANDVIEW AVE., SILVER SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6/21/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L CEM</b>	23d. LOCATION (City, town, or county) (State) <b>ARLINGTON VIRGINIA</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS Co - 1400 CHAMBERS ST.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 21 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



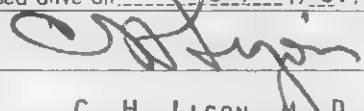
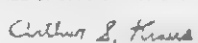
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# MONTGOMERY STATE DEPARTMENT OF HEALTH

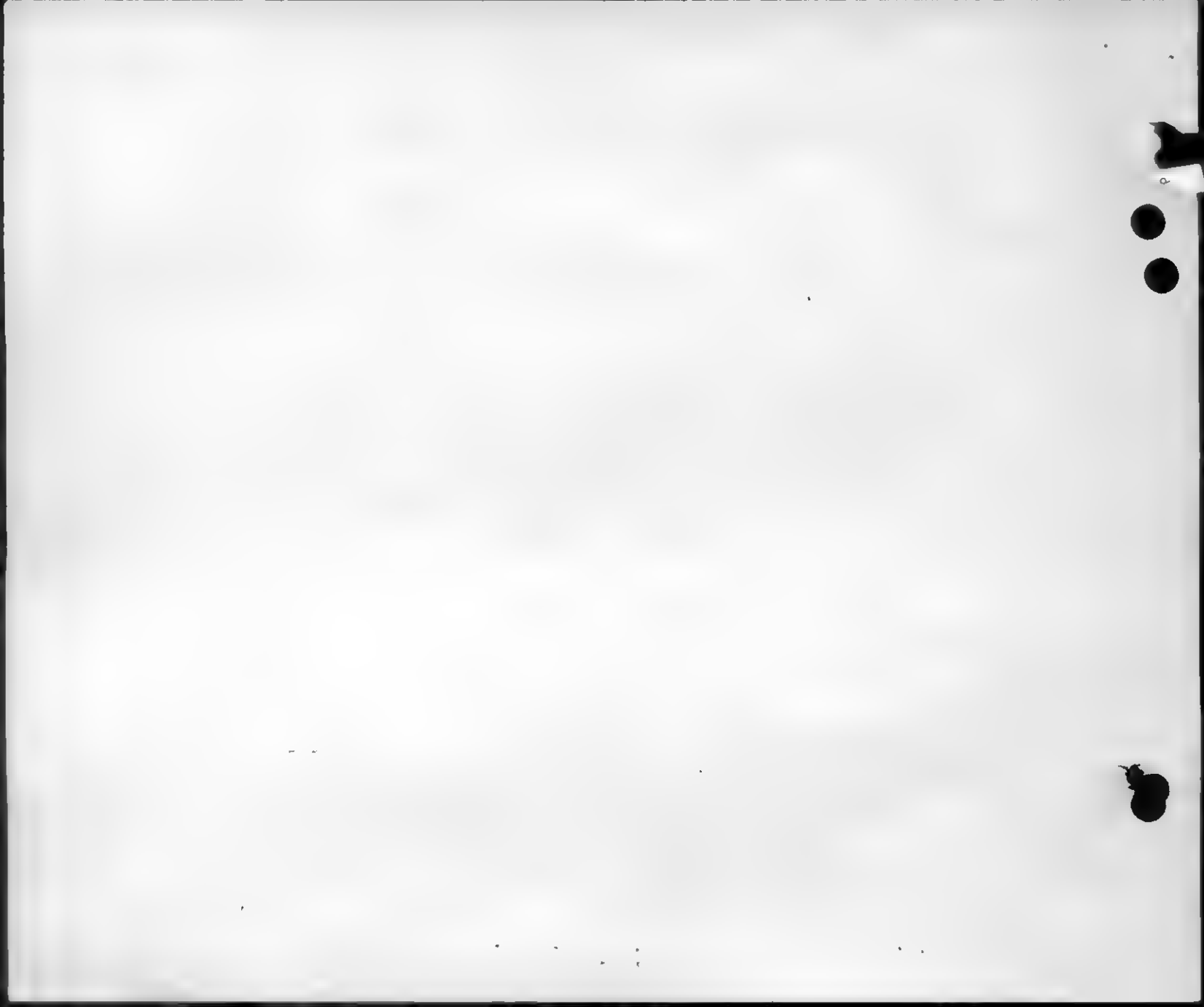
## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

07041

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>9 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PATRICIA</b> Middle <b>ELAINE</b> Last <b>WILLOUGHBY</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>7</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 29, 1961</b>		9. AGE (In years lost birthday) <b>9 DAYS</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>INFANT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILBERT HAR OLD WILLOUGHBY</b>				14. MOTHER'S MAIDEN NAME <b>ZELMA SHACKELFURD</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BILATERAL BRONCHO-PNEUMONIA</b> 7-2-61 DUE TO (b) <b>PREMATURITY (3-7-61)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-29-61</b> to <b>6-7-61</b> that (I) (we) last saw the deceased alive on <b>6-7-19 61</b> , and that death occurred at <b>6:23 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE 		M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/8/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M. D.</b>		22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/9/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		23d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home</b>				ADDRESS <b>1331 E. Montg. Ave. Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>12 '61</b>	
				25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death.



TO HOSPITAL: The law requires that the death certificate be returned to the hospital or attending physician within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7055

07042

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>33 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if different from residence before admission) a. STATE <b>Colorado</b> b. COUNTY <b>Trinidad</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1614 Buena Vista</b> d. STREET ADDRESS <b>June 11 1961</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Robert Elmore WILSON</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>June 11 1961</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5-14-09</b>	
<b>9. AGE</b> (In years, last birthday) <b>52 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Officer U. S. Navy</b>		<b>11. BIRTH-PLACE</b> (County & State or foreign country) <b>Illinois USA</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>John Carl WILSON</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha L. ELMORE</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 1928 to 1958</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>224-52-4475</b>		<b>17. INFORMANT</b> <b>(W) Mrs. Martha J. Wilson, 3222 1st Place, Arlington, Va.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) Adenocarcinoma, liver, with metastasis</b> <b>156.1 DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (b) DUE TO</b> <b>(a), stating the underlying cause last. (c)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4 mos.</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:</b>		<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> <del>the</del> (this hospital) attended the deceased from <b>May 9 1961</b> to <b>June 11 1961</b> , that <del>it</del> (we) last saw the deceased alive on <b>June 11 1961</b> , and that death occurred at <b>8:50AM</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <i>J. E. Stitcher</i>		<b>22b. DATE SIGNED</b> <b>6-12-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>J. E. STITCHER, LT, MC, USN</b>		<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>6-14-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington Virginia</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Arthur S. House</i>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JUN 15 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. House</i>			





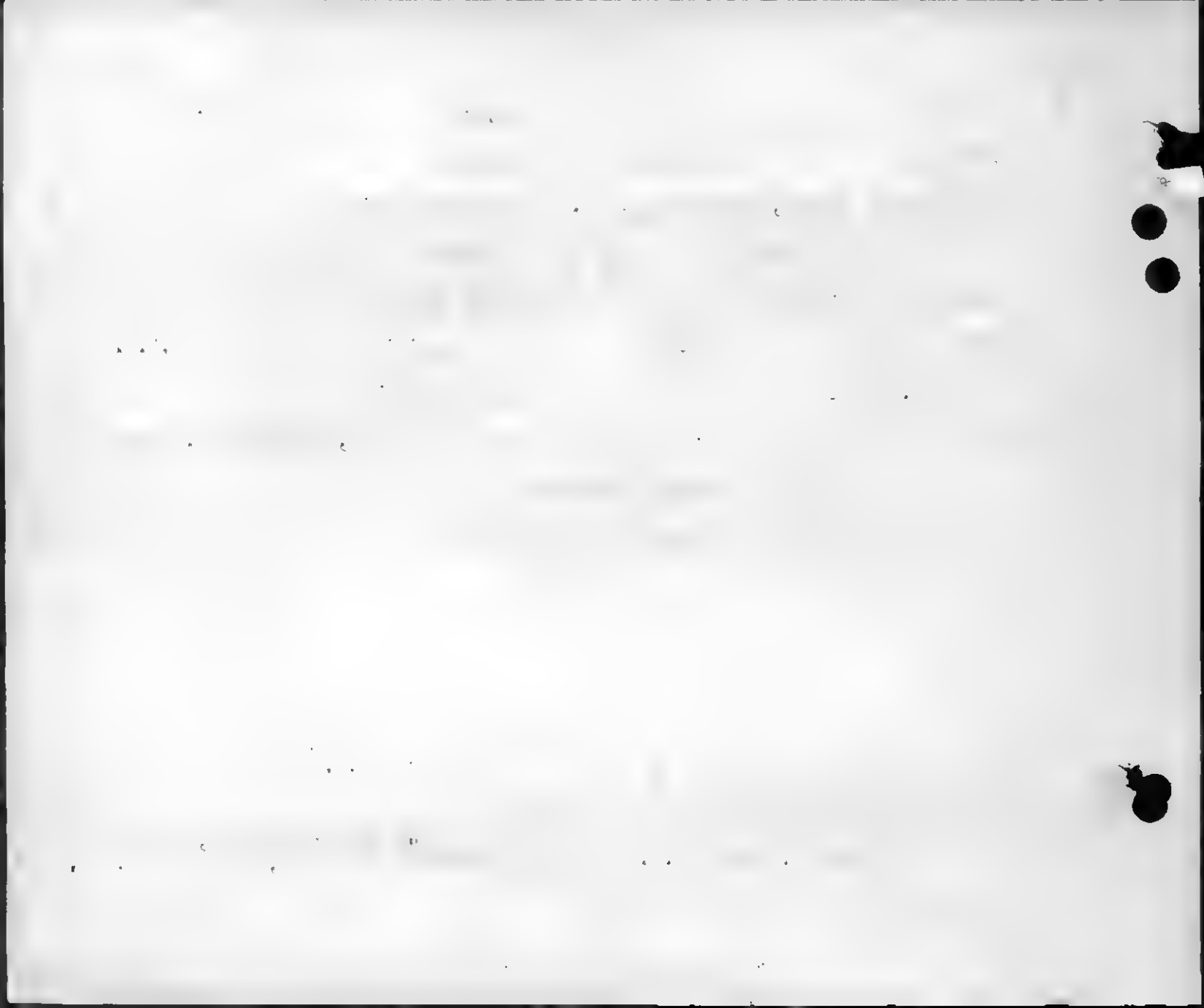
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7055

07043

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Frederick</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>25 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Winchester</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>610 Hillman Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marty</b> Middle <b>Ann</b> Last <b>Windle</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 24, 1956</b>	
9. AGE (In years last birthday) <b>5</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min.		11. IF UNDER 24 HRS Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Norman E. Windle</b>				14. MOTHER'S MAIDEN NAME <b>June Marshall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b> DUE TO (b) <b>Metastatic Wilm's Tumor</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>10 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 11</b> 19 <b>61</b> , to <b>June 5</b> 19 <b>61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 5</b> 19 <b>61</b> , and that death occurred at <b>9:40 p.m.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Jerome B. Block</i>				22b. DATE <b>6/8/61</b>		22c. PHYSICIAN'S NAME (Type) <b>JEROME B. BLOCK, M.D.</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>6-9-61</b>		<b>Lebanon Church Cn.</b>		<b>Lebanon Church, Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>				ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 8 '61</b>	
						25b. REGISTRAR'S SIGNATURE <i>Charles L. Kraus</i>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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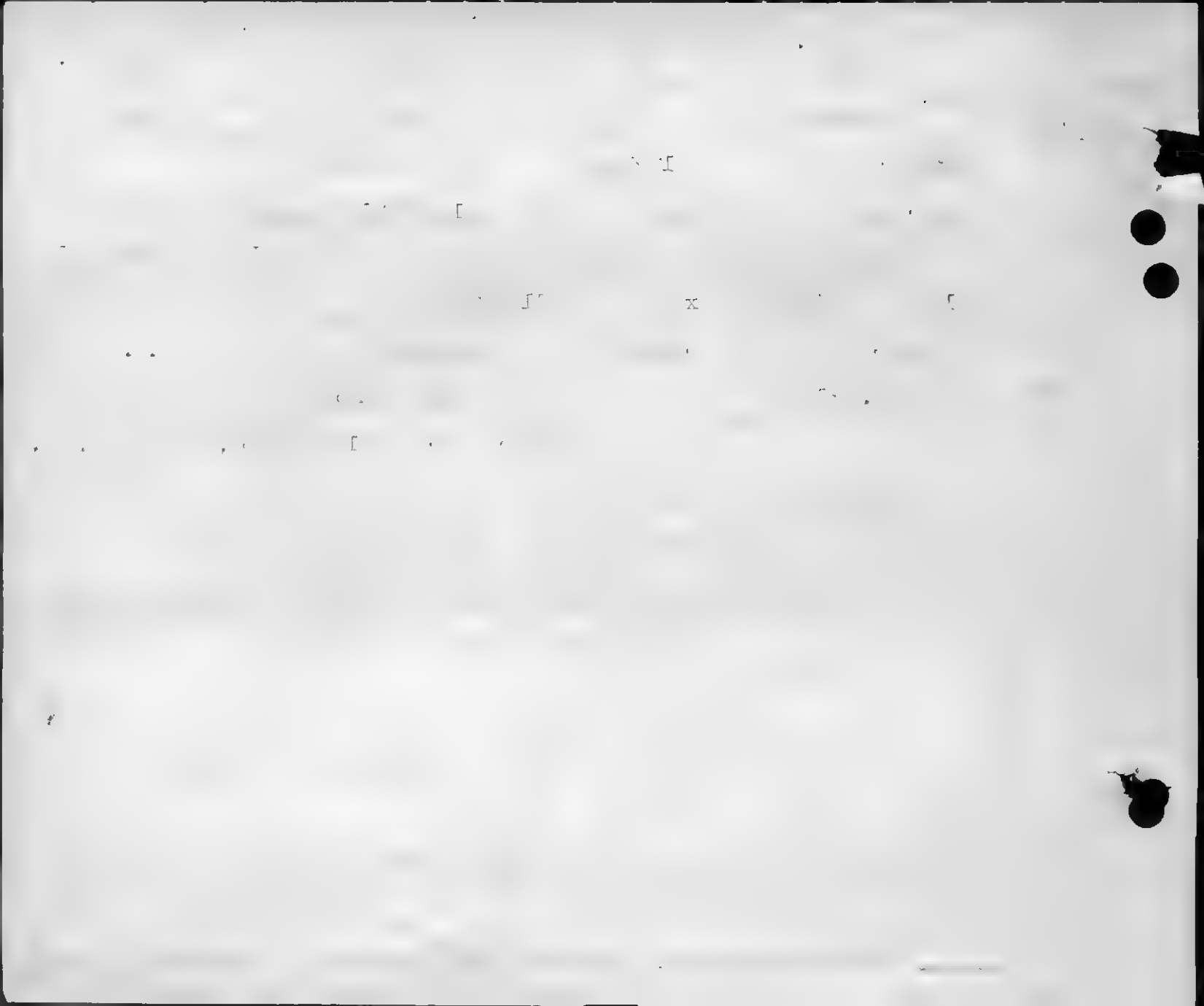
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7057

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07044

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>17 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>11709 Galt Avenue</b> e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas W. Woltz</b>		4. DATE OF DEATH <b>June 20 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/21/73</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>7</b> Min. <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13. FATHER'S NAME <b>Charles E. Waltz</b>	
14. MOTHER'S MAIDEN NAME <b>Mammie Landown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <b>578 67-405</b>		17. INFORMANT <b>Grace DeGroat</b> Address <b>15 Erickson, Cabin John, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure &amp; Emphysema</b> DUE TO (b) <b>Prostatitis &amp; Kidney Involvement</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Fr. of Ret. Hip</b> DUE TO (c) <b>Fr. of Ret. Hip</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 4, 1961</b> to <b>June 20, 1961</b> ; that (I) (we) last saw the deceased alive on <b>6/20/61</b> 19 <b>61</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22d. ADDRESS <b>8106 Maple Ridge Rd., Bethesda, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-23-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town or county) (State) <b>Bethesda Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		25a. REC'D BY REGISTRAR <b>[Signature]</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
ADDRESS <b>1812 9th Ave. NW, DC</b>		DATE <b>JUN 23 '61</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

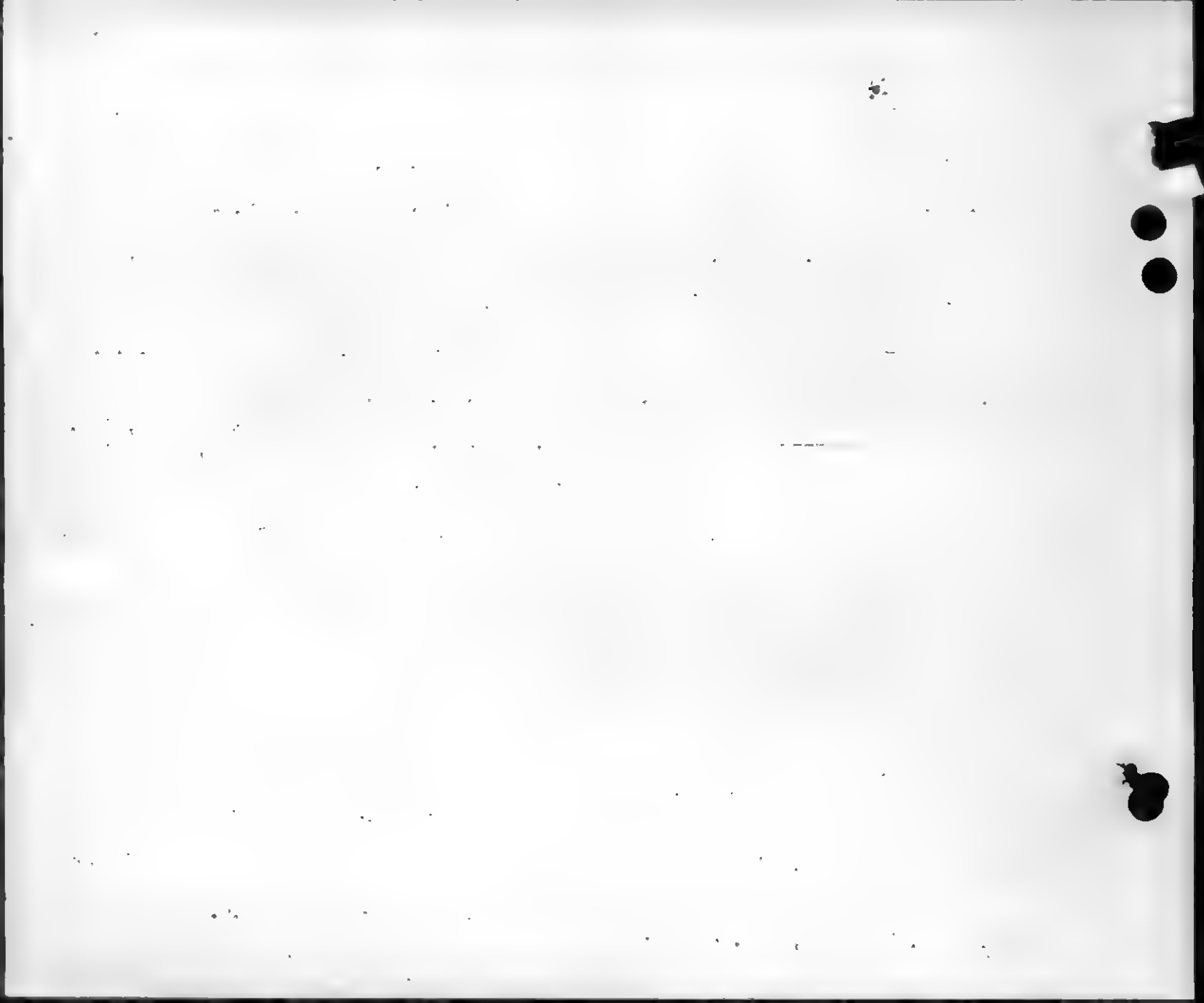
## CERTIFICATE OF DEATH

Reg. Dist. No.

07045

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>	
c. LENGTH OF STAY IN 1b <b>8 months</b>		d. STREET ADDRESS <b>8712 Colesville Road, Apt. # 408</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mrs. Bartlings Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mrs. Ella A. Wood</b> Middle <b></b> Last <b></b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1961</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/14/73</b>
9 AGE (in years lost birthday) <b>87</b> yrs		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	11. IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker -- Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Boston Massachusetts</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mr. George Averill</b>		14. MOTHER'S MAIDEN NAME <b>Mrs. Georgianna Kendall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mr. Grant A. Wood</b>		Address <b>8712 Colesville Road, Apt. 408</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b></b> a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 1957, to <b>June 12</b> , 1961, that I last saw the deceased alive on <b>June 11</b> , 1961, and that death occurred at <b>7:20 A.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Seruch T. Kimble</b>		ADDRESS (Street, city or town, state) <b>927 P. Washington Drive, Silver Spring, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Seruch T. Kimble</b>		DATE SIGNED <b>6-12-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/14/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>		24a. REC'D BY REGISTRAR <b>JUN 15 '61</b>	
ADDRESS <b>8434 Georgia Avenue Silver Spring, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. It may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

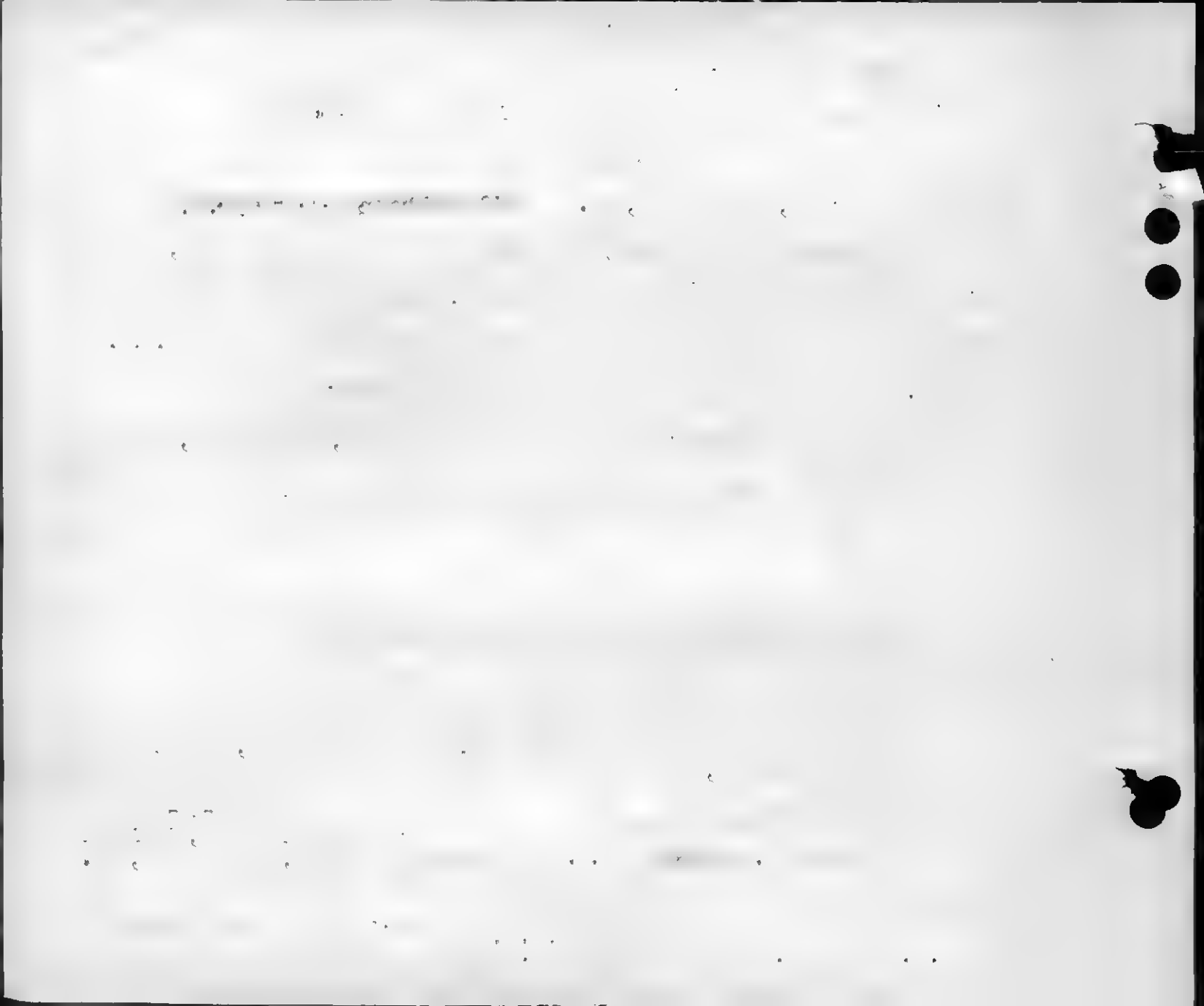


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07046

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) STATE <b>District Of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. STREET ADDRESS <b>1721 Kilbourne Place, N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Harlan</b> First <b>(None)</b> Middle <b>Wood</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>12,</b> Year <b>19 61</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 4, 1896</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John C. Wood</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Cannon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes No, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Records</b> address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162-1</b> <b>Bronchogenic carcinoma, disseminated</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aortic Insufficiency, myocardial infarction</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 25, 1961</b> to <b>June 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 12, 1961</b> , and that death occurred at <b>5:59</b> P. M. from the causes and on the date stated above			
22a. SIGNATURE <b>Michael W. Brandriss</b> M.D.		22b. DATE SIGNED <b>6-12-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Michael W. Brandriss M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/16/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. - Arlington Virginia</b>	23d. LOCATION (City town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co. 2901 14th St., N.W.</b>		25a. REC'D BY REGISTRAR <b>JUN 14 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed by the attending physician or attending physician, hospital or funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No. 07047

7060

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven Rest Home</u>				e. STREET ADDRESS <u>8505 Flower Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>B</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 1 1917</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Broughton</u>				14. MOTHER'S MAIDEN NAME <u>Julia Terwilliger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address <u>W. Albert Wright</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 21, 1960</u> to <u>June 19, 1961</u> , that I last saw the deceased alive on <u>June 18, 1961</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>				DATE SIGNED <u>6-19-61</u>			
22a. BURIAL, CREMATION, REMOVALS (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 22, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll St NW. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. S. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

270

Name of deceased		Sex		Age		Date of death	
John J. Smith		Male		45		Jan 15, 1910	
Place of birth		Usual residence		Cause of death		Manner of death	
New York City		New York City		Heart disease		Natural	
Occupation		Signature of physician		Signature of registrar		Signature of informant	
Clerk		[Signature]		[Signature]		[Signature]	
Date of burial		Place of burial		Name of funeral home		Name of undertaker	
Jan 20, 1910		St. Paul's Church		[Name]		[Name]	
Name of informant		Address of informant		Signature of informant		Signature of registrar	
[Name]		[Address]		[Signature]		[Signature]	
Date of certificate		Signature of registrar		Signature of informant		Signature of registrar	
Jan 25, 1910		[Signature]		[Signature]		[Signature]	

LETTER OF  
TESTIMONY  
TO BE  
FILED IN  
THE  
OFFICE OF THE  
REGISTRAR  
OF DEATHS  
IN THE  
CITY OF  
BOSTON  
MASSACHUSETTS  
JAN 25 1910

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
VR A15 (4)  
15M 9/60

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7061  
MONTGOMERY STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
07043

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>10503 Drumm Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-21-61</b>
9. AGE (In years last birthday) <b>2</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		12. KIND OF BUSINESS OR INDUSTRY -----	
13. FATHER'S NAME <b>Herman ZIFFER</b>		14. MOTHER'S MAIDEN NAME <b>Kathleen Mary MORRISON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(F) Herman Ziffer, same as #2 above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity with immaturity (Birth wgt. 1# 15 oz)</b> 776 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>June 21, 1961</b> to <b>June 23, 1961</b> , that (X) (we) last saw the deceased alive on <b>June 23, 1961</b> , and that death occurred at <b>9A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert V Rack</b> M.D.		22b. DATE SIGNED <b>6-23-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. RACK, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>26 Jun 61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>J. Wm. Lees Sons Co.</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Everly Funeral Home, Fairfax, Va.</b>		25a. REC'D BY REGISTRAR <b>JUN 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. DATE <b>JUN 27 '61</b>	

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